UNIVERSITY OF ALBERTA

DO PARAMEDICALS HAVE OCCUPATIONAL CONTROL? A STUDY OF PHYSICAL THERAPY AND RESPIRATORY THERAPY IN ALBERTA, 1988

BY

BETH M. CHIASSON

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DEPARTMENT OF SOCIOLOGY

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ABSTRACT

This study was conducted to ascertain if two paramedical occupations have achieved formal control of their activities. If so, over what aspect and if not, what restrictions are in place; that is what power is held over them by another group.

Government documents were examined for privileges and restrictions on dimensions specified within a theoretically defined "framework of occupational control" generated initially from the literature. A description of each profession's configuration following the dimensions of the framework was given. The relationships of each occupation to medicine and the state were also described. The two occupations were compared and contrasted in order to ascertain their relative positions within the economic and political marketplaces of the health care system.

Within these documents, privileges and restrictions are specified in different ways. There are specific terms in the legislation that directly relate to control and power such as the specification of an occupation's scope of practice. There are also terms within the legislation that establish government agencies and occupational bodies such as the Health Disciplines Board and the Physicial Therapy Council, and which enable the bodies to act authoritatively by investing them with administering and governing rights. This second means of gaining occupational control through these agencies can either reinforce or negate any

occupational control secured through the first means.

It was concluded that paramedical occupations do have occupational control but the extent and the form differs. Physical Therapy has a degree and form of control that is stronger than Respiratory Therapy. The state retains substantial administrative and governing power over the activities of both paramedicals. It was more extensive and direct over Respiratory Therapy than Physical Therapy. Medicine's power over the paramedicals is held primarily through its position on government agencies with administering rights. Medicine has more power over Respiratory Therapy activities than Physical Therapy activities, both through the specific terms of the legislation and through its position on government agencies invested with administering rights.

The pattern of power evident in the state-medical-paramedical relationship as exemplified by Respiratory Therapy is identified with the label "state dominated tripartite relationship". The more balanced relationship of Physical Therapy is identified with the label "occupational dominated tripartite relationship".

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TABLE OF CONTENTS

PAGE

CHAPTER I: INTRODUCTION 1

CHAPTER II: REVIEW OF THE LITERATURE

A. INTRODUCTION 9
B. MEDICAL DOMINANCE 11
C. SOCIAL CLOSURE 18
D. OCCUPATIONAL IMPERIALISM 23
E. RESEARCH DIRECTION 30

CHAPTER III: LEGISLATIVE CONTEXT

A. INTRODUCTION 35
B. THE PROVINCIAL CONTEXT 36
C. FORM OF LEGISLATION 42
D. PHYSICAL THERAPY AND RESPIRATORY THERAPY 46
E. SUMMARY 51

CHAPTER IV: METHODOLOGY

A. INTRODUCTION 53
B. RESEARCH DESIGN 56
C. DATA COLLECTION 64
D. DATA MANAGEMENT 66
E. DATA ANALYSIS 73
F. SUMMARY 75

CHAPTER V: FRAMEWORK OF OCCUPATIONAL CONTROL

A. INTRODUCTION 76

B. LEVEL I: DIMENSIONS OF CONTROL WITHIN THE ECONOMIC MARKETPLACE 78

  Entitlement Conditions of/for Occupational Membership 80

  Entitlement Rights of Supply of Services . . . 85

C. LEVEL II: DIMENSIONS OF CONTROL WITHIN THE POLITICAL MARKETPLACE 94

    Administering Rights 95

    Governing Rights 110

CHAPTER VI: LEVEL I - DIMENSIONS OF CONTROL WITHIN THE ECONOMIC MARKETPLACE

A. INTRODUCTION 117

B. ENTITLEMENT CONDITIONS OF/FOR OCCUPATIONAL MEMBERSHIP 118

  Right to Title 118

  Occupational Credentials 120

  Code of Ethics 127

C. ENTITLEMENT RIGHTS OF SUPPLY OF OCCUPATIONAL SERVICES 131

  Scope of Practice 131

  Gatekeeping Rights 132

  Domain of Work 135

  Income Structure 147

CHAPTER VII: LEVEL II - DIMENSIONS OF CONTROL WITHIN THE POLITICAL MARKETPLACE

A. INTRODUCTION 153

B. ADMINISTERING RIGHTS 153

Register Management 154

Register Administration 156

Administrative Responsibility by Government . 165

Administrative Co-ordination by Government . 181

Administrative Change by Government 184

C. GOVERNING RIGHTS 196

Indirectly: By the Legislature 197

Indirectly: By the Lieutenant-Governor-in-Council 198

Indirectly: By Ministerial Order 202

Directly: By Occupational By-Law 209

CHAPTER VIII: DISCUSSION

A. INTRODUCTION 213

B. FORMS OF OCCUPATIONAL CONTROL 214

C. PATTERNS OF POWER 228

D. CONCLUSION 235

CHAPTER IX: CONCLUSION

A. WHAT WAS GAINED BY THIS RESEARCH? 247

B. FUTURE DIRECTIONS 252

C. CONCLUSIONS 255

BIBLIOGRAPHY 259

APPENDIX I - OFFICIAL 1988 GOVERNMENT DOCUMENTS 273

LIST OF TABLES

TABLE 1: SUMMARY OF FORMAL OCCUPATIONAL CONTROL OF THE ECONOMIC MARKETPLACE: PHYSICAL THERAPY AND RESPIRATORY THERAPY 215

TABLE 2: SUMMARY OF FORMAL OCCUPATIONAL CONTROL OF THE POLITICAL MARKETPLACE: PHYSICAL THERAPY AND RESPIRATORY THERAPY 216

LIST OF FIGURES

FIGURE 1: A FRAMEWORK OF PARAMEDICAL OCCUPATIONAL CONTROL: EARLY VERSION. 61

FIGURE 2: EXAMPLE OF A CARD 69

FIGURE 3: CHAIN OF EVIDENCE FROM ONE PIECE OF LEGISLATION: SELECTED SECTIONS 70

FIGURE 4: EVIDENCE FOR OCCUPATIONAL CREDENTIALS (FROM LEGISLATION) 71

FIGURE 5: FRAMEWORK OF OCCUPATION CONTROL 79

LIST OF ABBREVIATIONS

AA - Alberta Act.

ADL - Public Health Act. Alberta Aids to Daily Living and Extended Health Benefits Regulation.

AHA - Alberta Hospital's Association Act.

BNA - British North America Act.

COA - Department of Community and Occupational Health Act.

COR - Department of Community and Occupational Health. Annual Report.

GAI - Alberta Executive Council. Inventory of agencies, boards and commissions, 1988.

GAO - Alberta. Executive Council. Organization of the Government of Alberta, August 1987.

HA - Hospitals Act.

HAR - Hospitals Act. Operation of Approved Hospitals Regulations.

HBR - Hospitals Act. Alberta Hospitalization Benefits Regulation.

HCR - Public Health Act. Coordinated Home Care Program Regulation.

HDA - Health Disciplines Act.

HDR - Alberta Health Disciplines Board. Annual Report.

HFCA - Health Facilities Review Committee Act.

HIA - Alberta Health Care Insurance Act.

HIB - Alberta Health Care Insurance Act. Claims for Benefits Regulation.

HICR - Alberta Health Care Insurance Act. Assessment Committee Regulation.

HIR - Alberta Health Care Insurance. Alberta Health Care Insurance Regulation.

HMA - Department of Hospitals and Medical Care Act.

HMGR - Department of Hospitals and Medical Care Act. Grants Regulations.

HMP - Alberta Department of Hospitals and Medical Care. Good Health is everybody's business: taking care of the Alberta health care system. pamphlet

HMR - Alberta Hospitals and Medical Care. Annual Report.

HR1 - Premiers Commission on Future Health Care for Albertans, June 1988. Interim Report: Caring and Commitment: Concerns of Nurses in the Hospital and Nursing Home System.

IA - Interpretation Act.

LAA - Legislative Assembly Act.

MPA - Medical Profession Act.

MPB - Medical Profession Act. Bylaws of the College of Physicians & Surgeons.

MPBR - Alberta Health Care Insurance Act. Medical Benefits Regulation.

PCOC - Premier's Commission.- Order in Council - Dec. 1987.

PCIR - Premier's Commission - Interim Report - June 1988.

PC188- Premier's Commission - Newsletter - Sept. 1988.

PC288- Premier's Commission - Newsletter - Nov. 1988.

PC189- Premier's Commission - Newsletter - Sept. 1989.

PC289- Premier's Commission - Newsletter Special Edition - Dec. 1989.

PCRR1- The Rainbow Report - Dec. 1989 - Volume 1.

PCRR2- The Rainbow Report - Dec. 1989 - Volume 2.

PCRR3- The Rainbow Report - Dec. 1989 - Volume 3.

PGHA - Provincial General Hospitals Act.

PHA - Public Health Act.

POA - Professional and Occupational Associations Registration Act.

PTA - Physical Therapy Profession Act.

PTBR - Alberta Health Care Insurance Act. Physical Therapy Benefits.

PTR - Physical Therapy Profession Act. General Regulation.

RA - Regulation Act.

RTR - Health Disciplines Act. Respiratory Therapy Regulation.

SA - Societies Act.

UA - Universities Act.

CHAPTER I: INTRODUCTION

During the 1980s it became evident that the government of Alberta was developing a renewed interest in rewriting the terms of legislation for paramedicals who were already covered by an occupational act. Similarly, there was an interest in introducing new legislation for paramedicals who previously had none. These changes generated an impression that such activity was indicative of a trend toward rationalizing and equalizing the imbalance of power that exists between health occupations. Certainly, many members of local paramedical occupations were optimistic that they would acquire enhanced occupational control and power as a result of this process.

Do paramedicals have formal occupational control or power? If so, what form does it take? These questions became the driving motive behind the investigation reported in this thesis. Since the inquiry is concerned with the *formal* basis on control and power, the obvious data source for the study is legislation and other formal documents that specify legally granted privileges in an objective and accessible form. The paramedicals selected for the study are Respiratory Therapy (R.T.) and Physical Therapy (P.T.). The study is limited geopolitically to the province of Alberta and temporally to the year 1988.

There are relatively few studies addressing this question directly. However, there is a scattering of studies that bear directly or indirectly on the question: some were conducted in Canada (Boase 1982; Burtch 1988; Coburn and Biggs 1987; MacNab 1970; Renaud 1975, 1981), several were done in Britain (Armstrong 1976; Fielding and Portwood 1980; Larkin 1978, 1983; Ovretveit 1985) and one is reported from Australia (Willis 1983). Most of these employ a historical perspective. While the advantage of historical studies is in the yield of rich empirical detail, the disadvantage is that given the absence of agreement on what constitutes the general nature of the phenomenon, the research findings produced lack comparability.

Addressing the issue of comparability became the second objective of the research project. This objective is met by extracting, from a review of the literature, a set of dimensions which were then assembled into a framework of occupational control. The framework was developed initially as a provisional guide for reading the formal documents. Subsequently, as the framework was applied to the data it was also modified and elaborated.

The theoretical and methodological justification for the research project was derived from a body of literature in medical sociology that has a rather extraordinary preoccupation for studying medicine as a profession. This emphasis has the unfortunate consequence of leaving the field relatively barren of theoretical concepts and research instruments that are directly applicable to studies of paramedical occupations. Given this situation, the literature review (Chapter II) is organized around the writings of major works in the field. The review begins with a discussion of the work of Eliot Freidson, particularly the book *Profession of Medicine* (1970a) in which he presents a developed treatment of the medical dominance thesis. The two other major works reviewed are Berlant's *Profession and Monopoly* (1975) and Larkin's *Occupational Monopoly and Modern Medicine* (1983) paying particular attention to the ideas of social closure and occupational imperialism found within their respective works. All three works share the conviction that power and control are central ideas in the study of professions and occupations.

The chapters of the thesis are organized as follows: Chapter II, as noted above, contains the literature review. Chapter III briefly describes the legislative context. In Chapter IV the methodology of the comparative case study used in this project is outlined and the methodological role of the framework is discussed. Chapter V offers a selective review of literature showing the ideas and sources used in the development of the framework. The framework has two major divisions or levels, as they are called: the first relates to the closure and monopoly strategies associated with market control and the second relates to political control and primarily to the state apparatus which oversees the system. The descriptive findings, using the two levels of the framework as the organizing device are presented in Chapters VI and VII, respectively. Chapter VIII offers an analysis and discussion of the descriptive findings and the concluding comments are contained in Chapter IX.

The remainder of this chapter is devoted to a preliminary discussion of the study's results and conclusions. In this discussion, there is an effort to provide the major findings in an interpretive context.

Theorizing from the neo-Weberian position advanced by Berlant, it was assumed that an occupation's competitive position in the market could be enhanced by employing closure strategies to restrict membership. Essentially, closure practices function in an exclusionary way to define the boundaries of the group by establishing outsiders from insiders. There was evidence in the occupational acts that three interrelated but separate closure practices have been converted into legislation and encoded as legal privileges. They are listed in Table I of Chapter VIII under market control in cell A. They are identified as title, credentials and code of ethics.

With respect to title, the legal protection of membership boundaries which Respiratory Therapy has secured is stronger. Physical Therapy failed to secure the right to the earlier title physiotherapy. Accordingly, a practitioner who does not qualify for licensure under the **Physical Therapy Profession Act** could, in 1988 still practice as a physiotherapist. Observing the differences between the groups on the other two privileges, it may be seen that Physical Therapy's provisions are stronger. Their credentials for membership are more stringent and therefore more exclusionary. Over time this is likely to enhance the social status of the group. In addition, the code of ethics acknowledges the essentially economic nature of P.T. work and provides for regulated conflict among members of the occupation and between related health occupations. In contrast, the economic nature of the work of Respiratory Therapy is suppressed and transformed into service to be carried out under "co-operative" relations.

By making inferences from Larkin's and Berlant's writings on monopoly patterns it can be assumed that the market advantage of a group is further enhanced by securing a legal monopoly over the supply of services. This is particularly true in a market characterized by state funding. There is evidence in the occupational acts and in other scattered pieces of legislation - for example, a hospital act - that exclusionary practices have been partially but not fully encoded into legally recognized privileges. Four separate but related types of practices are identified. These are contained in Table 1 again in

Chapter VIII under market control in cell B.

Scope of practice refers to the skill area over which a full or partial monopoly has been secured. The pattern for Physical Therapy is the stronger pattern although it is not as strong as for medicine. The skill boundaries are delimited by the technologies applied in practice but the terminology used is sufficiently vague to permit the exercise of clinical discretion. More importantly, the act is tied to the Medical Profession Act thereby ensuring that medical expansion in related skill areas will result in occupational expansion for P.T.. Gatekeeping rights refer to an occupation's ability to control the entry of clients into the system generally and secondly, into their own skill area. Physical Therapy's capacity in this respect is restricted to receiving clients through medical referral whereupon practitioners have the right to determine which P.T. skills or services are required for patient care. The significance of this point is underscored by the additional two privileges: the right to establish a private practice and the right to charge according to a modified fee-for-service schedule. As Freidson's work has made amply clear, the securement of these monopoly strategies enhances autonomy in the workplace.

In each of the four dimensions related to the monopoly of services, the form of Respiratory Therapy is much weaker. The definition of the skill area is more restricted and more precisely defined. Since clients are referred by medical practitioners who also supervise their work, it is concluded that R.T. enjoys less independence from the regulatory control of medicine. In all respects, compared to P.T., R.T. has a smaller "corner" of the market and less control of the boundaries of it. The failure of R.T. to have their skill converted to an essential service in hospitals, which is incidentally, the most likely place of employment for R.T.s, represents a serious lack of control for the occupation. The one area within this occupation's territory that allows for some measure of freedom is the area of home care where services may be provided under a contract negotiated with the state.

Theoretical discussions of occupational power and control led to the distinction between the economic and the political marketplace. The latter refers to the institutional context which bears the responsibility, from a system perspective, for establishing and monitoring the rules which provide the conditions of monopolization and closure practices which in turn, have the effect of shaping the medical division of labour. In practical terms, this context consists of the governmental and quasi-governmental agencies, boards, bureaus and committees, including the self-regulatory professional associations, which together constitute the administering and governing apparatus of the state. The findings related to this discussion on political control are summarized in Table 2 of Chapter VIII. The reader is referred there for the tabular presentation. Perhaps the most important finding to be derived from Table 2 is the extent to which the state and its various representatives are actively involved in the structuring and maintenance of the medical division of labour. This can be illustrated easily by noting the lack of involvement of the paramedicals in the political marketplace. The terms "non-participating", "non-influential" and involvement through "submission" are indicative of the paramedicals' exclusion and indirectly of the state's activity. This is true even in the case of P.T. which has the self-regulating autonomy normally associated with medicine.

CHAPTER II: REVIEW OF THE LITERATURE

A. INTRODUCTION

In medical sociology any study of occupational control and power must take account of the contributions of Eliot Freidson. His major contribution has been to establish the contemporary framework for analyzing medicine and the other health occupations which together constitute the medical division of labour. The importance of Freidson's work - its impact and durability - is attested to by the publication of a special 1988 supplement of the *Milbank Quarterly*. This supplement is devoted to a discussion of Freidson's work particularly his thesis of medical dominance. Responding to a self-posed rhetorical question as who now reads Freidson, Wolinsky (1988, p.22), one of the contributors to the supplement, answers:"...anyone and everyone who desires to understand either the role of health and health care in American society, or the American health care delivery system itself." As the articles in this supplement make clear, Freidson's influence is not limited to the United States. Submissions describing research conducted in Britain (Larkin 1988), Canada (Coburn 1988) and Australia (Willis 1988) confirm Freidson's wide ranging influence.

The significance of Freidson's work is incontestable. This does not mean however, that his work has been received uncritically. Several authors claim, for example, that Freidson's depiction of medical dominance was correct but that since 1970, in the United States at least, medical dominance shows signs of erosion. Some have linked the erosion of medical dominance to the concept deprofessionalization (Haug 1988) or to proletarianization (Navarro 1988). The question of whether or not medical dominance is declining has stimulated an interesting debate but the way the debate is framed may obscure the more fundamental problem in Freidson's work. Larkin (1988) raises the very real prospect that the question is not whether Freidson's medical dominance thesis is dated but whether, its formulation from the beginning, is over-stated. The weight of the evidence (Baer 1989; Berlant 1975; Macdonald 1985; Ovretveit 1985; Saks 1983; Willis 1983) and consequently, the position taken in this study is that Freidson's formulation does over-exaggerate both medicine's independence from the state and its role as the principal determinant of the health division of labour.

The tendency which Freidson shares with others, to view medicine as "almost a 'state within the modern state' with either acquired or invested sovereignty" (Larkin 1988, p. 118) has led to an imbalance in theoretical and empirical interests resulting in a preponderance of studies on medical dominance but relatively few studies of paramedical control. While this outcome may be understandable, the situation presents this author with a dilemma as to how to proceed. There is no theory for paramedical control from which to derive hypotheses for testing; and there does not exist a large body of accumulated empirical facts from which to construct such a theory. Therefore, this review has the rather modest goal of trying to extract from the literature, most of which is framed within the language of medical dominance, the conceptual strands which are capable of providing a theoretical rationale and methodological direction to the present study. This is accomplished by reviewing Freidson's (1968; 1970a; 1970b; 1977; 1983; 1985; 1986a; 1986b) work on medical dominance; the neo-Weberian contribution on social closure, especially as put forward by Berlant (1975); and Larkin's (1983) application of the concept of occupational imperialism.

B. MEDICAL DOMINANCE

Freidson first presented his analysis of the profession of medicine and the medical division of labour in the *International Encyclopedia of the Social Sciences* (1968, p. 105-120) and later, in a slightly modified and greatly expanded form, in *The Profession of Medicine* (1970a) and *Professional Dominance* (1970b). These writings represent a departure from the taxonomic approach with its emphasis on traits and functions (Saks 1983). In rejecting the taxonomic approach, Freidson (1970b, p. 156) was self-consciously attempting "to remove the work (profession) from the realm of the normative"; he was accepting a structural rather than individualistic orientation; and he was substituting for the service ideal, an emphasis on power and control as fundamental to the nature of a profession. The approach which Freidson adopted has been loosely termed the power perspective (Macdonald and Ritzer 1988).

In rejecting the taxonomic approach, Freidson has not rejected the objective of abstract theorizing. On the contrary, he accepted medicine as the prototypical profession hoping to find in a study of the structure and processes of medicine, the universal principles associated with this unique form of occupation. Freidson's commitment to understanding the profession as a unique type of profession is illustrated in his demarcation between medicine and paramedicals as the distinction between a profession and a non-profession. Freidson (1970a, p. 49), having noted that "paramedical occupation may be distinguished from established professions by their relative lack of autonomy, authority and prestige", then proceeded to characterize paramedicals as "a sociologically distinct form of occupational organization". Clearly, this represents a slide back to the taxonomic approach distinguishing professions from non-professions on the basis of the presence or absence of power. The irony of this situation has not eluded Freidson.

More than a decade after the *Profession of Medicine*, Freidson (1983, p. 32) returned to the definitional problems associated with the term profession and acknowledged a complete break with the trait approach recognizing that "there is no single, truly explanatory trait or characteristic - including such a recent candidate as 'power'". Freed from the conceptual blinkers of the last remnants of the taxonomic approach, Freidson is able to abandon the concept of profession as a generic type and to see instead, as Johnson (1972) had earlier, that profession is merely a strong form of occupational control. This is an important development in the study of health occupations for it means that medicine and paramedicals are not distinct sociological types subject to different theoretical explanations. Rather, it means that any differences observed between medicine and paramedicals are the result of concrete historical processes at a given point in time and not the result of fixed universal laws or essences.

Consistent with this recent clarification, Freidson has recommended the adoption of a particular research strategy. Freidson (1983, p. 34-35) suggests:

> The strategy of analysis, therefore, is particular rather than general, studying occupations as individual empirical cases rather than as specimens of some more general, fixed concept. ...By expanding the universe of occupations on which we have detailed and systematic data, and by analyzing them as individual historic cases, we could establish the ground for

> catholic comparisons that we lack at present. Such a foundation would go far toward portraying the variety of contexts and inconsistencies intrinsic to the notion of profession, as well as the varied role of the notion in the fortunes of a number of occupations and their members in English-speaking societies. Such a portrait is certain to be richer and more varied than the abstract essence toward which the traditional literature aimed, but in being so, it is likely to be more faithful to reality.

If taken seriously, this methodological recommendation especially in light of the above definitional clarification, should encourage case comparative research on a whole range of health occupations other than, or, in addition to studies of medicine. This author has taken Freidson's recommendations seriously and this is reflected in the occupations selected for inclusion and in the design of a comparative case study.

Freidson (1985) continues to think that in the case of health occupations and the health delivery system, medicine is still the most strategic occupation to study. If this seems contradictory, the contradiction is more apparent than real. The apparent contradiction does not result from inconsistent methodological precepts or definitional problems. Rather, Freidson's (1985, p.12) belief that we should "focus on them (medicine) and on the way the changes of the past decade have affected them" rests on the assessment that the changes which have occurred on the health care field are merely "in the periphery of medicine's jurisdictional boundaries in the health division of labor"

(Freidson 1985, p. 32). As such, the observable changes of the past several decades, Freidson (1985, p. 32) continues, are only sufficient to "alter" but not to "actually transform ...the position of the medical profession". Freidson's assessment is that substantively, the theoretical position laid out in the original writings is still a valid account of the position of medicine and the structure of the health division of labour, at least as it applies to the United States context. Larkin (1983, 1988) has concluded, and this author agrees, that even if the original theoretical position is a valid depiction of the U.S. situation, the theory is nonetheless, incomplete.

The key to the power perspective generally and to Freidson's framework in particular, is "the possession of power. The power is used in regard to other occupations, organizations, clients, and the state" (Hall 1983, p. 12). Medicine viewed "as a group of workers joined together on the most general level by virtue of sharing a particular position in society and by common participation in a given division of labor" (Freidson 1970a, p. xvii) is an organized occupation which possesses power. From this it follows that "medicine has been given the right to control its own work" (Freidson 1970a, p.7) and given this autonomy over the content and conditions of its own work, it has "not merely freedom from the competition or regulation of other workers, but...also freedom to regulate other occupations" (Freidson

1970a, p.369). Accordingly, by virtue of its right to regulate other occupations, it follows that by "its position in the division of labour we designate it as a dominant profession" (Freidson 1970a, p.369). With regard to the power of clients, Freidson (1970a, p.369) continues "having the right to regulate its own work also implies that is has been granted the legitimate right to in some way regulate the clientele with which it works, rather than having to be finely responsive to the clientele's notions of its needs, like a mere salesman". Finally, with regard to the state, Freidson (1970a, p. 369) writes that the professional autonomy of medicine "is always limited to some degree by the political power which it needs to create and protect it, both those limits vary from time to time and place to place".

Although Freidson (1970a, p.23) explains the unique autonomy of medicine as a self-governing body and its structural position of dominance by reference to the state and in particular, to the support of the strategic elites, he does not provide a full explanation. He does not for example, explain which strategic elites supported medicine's claim for preeminent status or for what reasons the support was forthcoming. Neither does he explain what strategies medicine employed in presenting their claims. Also left unexplained is the means through which medicine's protected shelter is maintained. In fact, it appears that Freidson does not see this as problematic. Indeed, the assumption must be that it is not problematic. Apparently, the state grants physicians through licensure, a monopoly to penetrate the body, as "virtually the only one who can legally prescribe drugs and cut into the body" (Freidson 1970b, p.134). Whereupon the state loses further interest in the issue. This appears to be what Freidson (1970a, p. 369) is suggesting when he speaks of the characteristics of professional autonomy being such that it gives to members of the medical profession "a splendid isolation, indeed, the opportunity to develop a protected insularity without peer among occupations lacking the same privileges".

It is difficult to understand why, in the face of the rather cynical position that Freidson took with respect to medicine's ideological posture, he would take this somewhat naive position with respect to the state-medical relation. Perhaps, the explanation for this is a point made earlier by Hughes. Hughes (1958, p.85) attributes a good deal of the misunderstanding about occupational power and the political activities that occupations engage in to maintain their legal mandate "as a result of the strong fiction of political neutrality" in U.S. society. Whatever the explanation, there is an indication that Freidson's theoretical framework is deficient, or at least incomplete, since it fails to explain why the state takes such a passive position.

Freidson's framework also leaves unexplained how the profession of medicine structures the medical division of labour. It is clear that Freidson does not rely on technological determinism to explain the relationship between medicine and paramedicals. Although aware that many of the technically oriented health occupations developed in response to the introduction of technical innovations in the hospital, Freidson (1970a, p. 49) states explicitly that the paramedical occupations "are not merely part of a technologically differentiated division of labor"; they are more importantly, "part of a division of labor organized around and controlled by a central dominant profession". It is clear that within Freidson's framework, the medical division of labour is socially rather than technologically determined. By what social means is this accomplished? To look at the question from another perspective, we might ask the following: Why would paramedicals whom, according to Freidson (1970a, p. 368) like all occupations, seek "the prize (autonomy) sought by virtually all occupational groups" voluntarily remain subordinated to the power of medicine? Freidson's schema does not have a satisfactory solution to this dilemma.

C, SOCIAL CLOSURE

In *Profession and Monopoly* (1975), Berlant continues the theme of power and control established earlier by Freidson. While Freidson emphasized the consequences of power for control in the workplace, Berlant's project entails a redirection toward the strategies and conditions of power and control in the marketplace. Although this shift entails a departure from Freidson's schema it is not as Saks (1983, p. 6) observed earlier, inconsistent with it. In fact, Freidson's (1977, p. 24-25) later work incorporates the terminology of market control without actually changing his original position.

The real significance of *Profession and Monopoly*, over and above the historical analysis of the monopolization strategies which medicine has employed in British and American societies, is that Berlant develops the theoretical grounds for explaining why any occupation would, as a consequence of rational economic conduct, attempt to gain market control. In laying a neo - Weberian foundation for the study of occupational control, Berlant establishes the importance of strategic action and the role of the state. Berlant (1975, p. 47) writes:

> The success of a group, therefore, is a function of two broad determinants of economic action: The group's tactics of competition (or of conflict) and the conditions of competition. One major but not exclusive condition of competition in modern society is the state, which exercises both authoritative and de facto domination over groups within its territory. Since the body of norms for which the state acts as an enforcement staff is the legal order, politically oriented action by competitive groups must take into account the constraining effects

> of law and the competitive advantages of being able to influence legislation.

Berlant develops the theoretical rationale for the "groups tactics of competition (or of conflict)" by locating it within the ends-means schema of Weber's general theory of economic and social action as published in *Economy and Society* (1978).

Social closure occupies a central place in the foundation which Berlant builds. Social closure refers to the generic and elementary process of human action and group association. In its application to market control and the formation of occupational organizations to further this end, Berlant stresses the role of exclusionary (as opposed to expansionist) practices. Following Weber, Berlant (1975, p. 46) establishes that groups can "to an extent alter... their chances of success under given conditions of conflict" by restricting or expanding its membership. Restriction he continues "requires the capacity to deny membership to some who wish it". Therefore, it follows: "Restriction, or monopolization, then is dominative as well as economic process inasmuch as the group attempts to interfere with the will of others."

Closure practices may take many forms some of which are informal. However, those of greatest significance, presumably due to their efficiency over informal practices, are the formal practices enforced by the power of the state's legal apparatus. Berlant (1975, p. 48) notes that a group that has succeeded in gaining the latter form of closure becomes what; "Weber calls a legally privileged group, a group with a legal privilege to hold a monopoly." Typically, for occupations pursuing legally sanctioned exclusionary practices, the basis for determining inclusion and exclusion and the method of regulation is an "acquired characteristic" or credential, to use the current terminology.

State legislation or licensure then assumes theoretical and methodological prominence. Licensing serves as a strategic end pursued by occupations, as the embodiment of exclusionary codes and as the means through which the state underwrites the power of the occupation to control its members and supply of services. In addition, statutory documents are, as Bucher and Strauss (1961, p331-332) acknowledged earlier, the historical deposits of occupational struggles and conflicting relationships.

Berlant does not offer an explicit or codified set of occupational strategies for testing. In fact, his discussion suggests that the particulars will vary as occupations adapt to the contingencies of historical conditions and the realities of socio-political constraints. The real value of his writing lies in the development of a framework which establishes the necessity of analyzing occupational control according to strategies employed. His own study of the rise of medicine points to the strategic significance of a code of ethics as an ideological tactic in securing state support and in adapting to the different political climates that existed in British and American societies at the beginning of the twentieth century.

Two other studies in particular, provide general support for the neo-Weberian position advanced by Berlant. Turner (1981) adopts this general approach and shows how the development of nursing can be fruitfully studied by focusing on closure practices. Turner concluded that the result of the various modes of closure and the securement of legal registration was to increase the market scarcity of nursing skills and to raise the economic cost of their provision. Macdonald (1985) also adopts the social closure perspective to analyze how accountant's repeated attempts in Britain to obtain a legal monopoly, failed. These studies, including Berlant's own analysis of the medical profession, show that his general orientation, informed by considerations of social closure, opens up to empirical analysis the historical conditions under which occupations pursue professionalization, or monopolization, strategies and the role of the state in converting the occupation to the status of a profession.

The point has been made several times in the preceding discussion of Berlant's work; that the state in modern society plays an integral role in monopoly formation and professionalization. In fact, he acknowledges that occupational monopolies, in particular the monopoly of medicine did not arise until the hold of traditional institutions has been broken. In this respect, Berlant (1975, p.302) asserts "the rise of an emergent state power" and the rise of medicine as a form of monopoly control are causally linked.

Nonetheless, Berlant's view of the state has been, with some justification, criticized for being passive. Saks (1983), for example, points out that even though neo-Weberians, including Berlant, acknowledge the dependence of medicine's power on the state, they tend to see the state in terms of constraints. This view conceives of the state as the holder of power "from which power is wrung" through the collective efforts of the group (Macdonald and Ritzer 1988, p. 267).

D. OCCUPATIONAL IMPERIALISM

In *Occupational Monopoly and Modern Medicine* (1983) Larkin introduces the concept occupational imperialism as the organizing theoretical term. He selects this term in favour of the terms social closure or professional dominance. This choice signals continuity and discontinuity with the earlier work of Berlant and Freidson. Like the previous authors Larkin continues to emphasize power and control in considering occupations and to see the profession as a strong form of monopoly control. However, Larkin distinguishes himself from the earlier writers by attempting to overcome the limitations inherent in the work of Berlant with respect to the state and social closure and in the work of Freidson with respect to medical dominance and the medical division of labour.

As noted above, Berlant's theoretical presentation of Weberian concepts tends to provide for the state, a relatively passive role viewed as a constraint or as a constellation of interests. Perhaps this stems from assuming that a free market economy is the relevant context. Interestingly, in analyzing the historical materials from the British case in particular, he has not overlooked the fact or consequence of state funded health care. The distinction between defacto and dejure monopoly patterns and Berlant's own discussion of the British context seems to require a more active conception of the state than his theoretical discussion allows. He concludes, for example, that "unlike the profession, the state has the resources and administrative mechanism for shaping the medical market in a monopolistic direction"; and with a more direct reference to the economy, he notes, "the greatest material advances of the profession were due to the profession-state liaison and not to 'free enterprise' as understood in its laissez form" (Berlant 1975, p.305).

The view of the state as playing a more active and initiating role found in these conclusions is more consistent with the view presented earlier in Britain by Johnson (1972) and the position taken by Larkin (1983), as well as by a number of authors who describe the health care market in Canada (Crichton 1976; Charles 1976; Tuohy 1980; Weller 1977). Evans characterizes the medical-state relationship as a monopoly-monopsony relationship reflecting the profession's position as the exclusive supplier of medical care and the position of the state as the single, or almost single, provider of funds. Such an arrangement provides for an inherent structural contradiction offering mutually opposing and inter-dependent interests. In this situation the state must be seen to have a more active role than that initially allowed for in Berlant's theoretical discussion.

The precise nature of state action has been the subject of a stimulating debate between neo-Weberians and neo-Marxists. One of the difficulties deriving from a neo-Weberian view is that the societal divisions which result from professional-state monopolization and from the struggle over occupational boundaries is presented as a stratification system that is essentially distributive in nature. The criticism, from a Marxist position is that, in the final analysis, such a view fails to link the medical division of labour to the class structure and to the relations of production. This is a challenge which Murphy

(1984) has responded to; he has attempted to modify the social closure theory by linking this concept to class relations making a primary distinction between exclusionary practices based on property as opposed to those based on credentials. Central as this discussion is for the sociological enterprise, a more lengthy treatment of the topic is beyond the scope of this study.

What is immediately relevant for this research topic is a caution which Palmer (1985) serves to both Marxist and Weberian scholars. Palmer points to the tendency to theorize about the state as if it were a highly abstract and monolithic entity. He recommends that the advancement of state theory requires detailed empirical study of the vast governmental and quasi-governmental agencies, including the professional self-regulating bodies, paying attention to the complex and conflicting forms of autonomy and dependency. Heeding Palmer's caution, this study adopts a definition of the state which was put forward by Child and Fulk (1982, p.172): "the state", they write, "is defined here as the total domain of official public action rather than as government in the narrow sense. Its agencies therefore include government departments and subsidiary offshoots, commissions and review bodies established by government, and the judicial system."

The discussion of the state as the state-medicine relation has, Larkin points out, implications for theorizing about the medical division of labour and for the position of medicine and the paramedicals within it. Paramedicals interested in changing the occupational boundaries and those who study paramedicals and their boundaries must, as Freidson acknowledged earlier, take account of the fact that medicine's monopoly precedes in time. This is particularly true of the paramedicals who are studied in this project. The pre-existence of medicine's monopoly to most paramedicals of the type studied here, is well documented in historical accounts in the United States (Starr 1984), Britain (Berlant 1975), Australia (Willis 1983) and Canada (Hamowy 1984). This is significant, for theories must not ignore the tripartite relation that exists between the state, medicine and paramedicals. Having analyzed the development of four paramedical occupations in Britain, Larkin emphasized the need for conceptualizing all health occupations within the tripartite context, In this regard Larkin (1983, p. 21) writes. "Negotiations (over closure restrictions and boundary definitions) typically were open, and recognized as 'three-cornered', i.e., state, medical profession, and paramedical occupations, which is not to say that a state-doctor alliance did not exist."

Larkin's attention to the tripartite relation is a reaction for Freidson's conception of medical dominance and the corresponding "tendency to accept the 'state within a state' concept" (Larkin 1983, p.117). To see medicine as sovereign, according to Larkin, results from a tendency to view the state as passive and medicine in isolation. Occupational imperialism, a concept borrowed from development theories, is introduced to rectify this.

By using the term occupational imperialism in a metaphoric rather than literal sense, Larkin intends to signify several new directions which do not contradict but extent the work of Berlant and Freidson. This term signifies a sift away from the more individualistic notion of Weber's social action, as well as a shift away from the state within a state concept, to a more systemic approach. This is consistent with the earlier mentioned concept of a tri-partite relation. By focusing on the occupational boundaries of the occupation studied as well as on the boundaries of the system as a whole, one can see that occupations which constitute the whole also contribute to its overall shape. This view accords with the historical facts of the four paramedicals studied. Larkin (1983, p.191) observes that: "The occupational groups (the paramedicals who, in each case, had made claims to the state for monopoly control) did not set out to dominate in Freidson's sense but to negotiate role boundaries with a senior and more powerful partner." This is an important point because, he continues: "To a degree they achieved their ends, and in an important sense also contained medical expansionism."

Larkin introduces the distinction between functional and fundamental control which has parallels with the distinction between occupational boundaries based on specific tasks and boundaries of the overall system. It is possible then, for a paramedical occupation to achieve functional control - or an occupational monopoly through exclusionary practices along the lines suggested by Berlant's discussion of market control through social closure - but not to achieve fundamental control. That is, in the latter sense, the occupation may not have achieved control at the systemic level where the rules which establish the boundaries, the nature of the credentials and so forth, are actually negotiated and set. The bargaining arena at the systemic level has been appropriately called the political marketplace by Gravelle (1985, p. 1050).

It is worth repeating these points using Larkin's own words. "When considering the challenge which one occupation represents for another, it is important to distinguish between monopolizing individual skills (functional control) and controlling the overall context of development (fundamental control)" (Larkin 1983, p. 182). This relates more directly to the social closure concept in as much as: "Paramedical occupations develop within established boundaries of competence, and it is this kind of development which state registration licenses" (Larkin 1983, p. 182). In a slightly different context, Larkin (1983, p. 185) refers to the fact that paramedicals may, using the closure practices of market control, be successful at "'cornering' a section of the market" while not necessarily, gaining power or control in the political market.

Compared to Freidson's discussion of autonomy and medical dominance, Larkin's treatment of the medical division of labour entails a more relativistic and complex picture. Larkin suggests that this is a needed corrective to the tendency of Freidson to conceive of medical dominance and paramedical autonomy as zero-sum relations in which one group wins at the expense of the other. "Licensure is not a 'once only' or zero-sum process in which recognition of any one group brings exclusion of all others" (Larkin 1983, p. 8). Some functional control may even be conceded, he writes, "by a dominant occupation in order to retain control of the fundamental division of labour" without, in this respect, losing fundamental control of the system as a whole.

E. RESEARCH DIRECTION

The basic research questions that drives the study reported here is: do paramedicals have any formal occupational control or power? If so, what form does it take? Although relatively few studies have addressed this or related questions directly, the studies which have been published suggest that the answer is probably a qualified yes. Of the few relevant studies conducted in this area, most are done from a historical perspective. While the advantage of historical studies is that they produce results which are rich in detail, the disadvantage is that without any consensus about what constitutes the general issues in need of research, the findings produced, lack comparability. For this reason, the research strategy was to compare two paramedical occupations at one point in time. The prior task, given the absence of any models or theory in this area, was to develop from a review of the literature, a provisional framework capable of producing comparative results as a first step in theory development. The framework and the literature from which it is derived, are reported in Chapter V.

In reviewing the literature reported here, the main objective was to find in the literature, framed primarily in terms of medical dominance, the methodological and theoretical strands which would give overall direction to the project. Freidson's recommendation to conduct case studies on different and understudied health care occupations is basically supportive of the direction taken for this project. The identification by Bucher and Strauss (1961) that statutory documents may be read as the deposits of the historical struggles for power and control provides the methodological justification for using legislation and other related official documents as the data base. Theoretical justification is found in the convergence of ideas from all the authors reviewed. Without exception, there is agreement that the licensing is key to the issues of power and control and that legal statutes codify the extent and form of occupational control and relations of power that have been won or granted through the political process. The following directive for reading the documents may be derived from the literature: recognition of control will be facilitated by searching for rights and privileges granted; power relations will be, in part, reflected in stated restrictions.

In developing the framework and analyzing the documents, attention will be directed toward exploring the concepts emphasized in the literature reviewed in this chapter. These include social closure, monopoly of services, functional and fundamental control, the role of the state and the tripartite relation of state, medicine and paramedicals. A vital distinction uncovered in the literature reviewed is the distinction between control in the economic marketplace and control in the political marketplace. The suggestion was that these are distinct domains which can not be meaningfully collapsed into a single dimension. In some instances, to be empirically determined, control may be evident in both contexts, in others, market control may be reinforced by political control but the reverse is most improbable.

Finally, the definitions which seem best suited for clarifying the task at hand follow:

The definition of paramedical occupations follows Larkin. Accordingly, paramedicals are occupational groups, other than doctors, who are seeking or have sought occupational licensing; who deal directly with the patient; and who are paid for patient services (Larkin 1983, p.2). The term 'occupational control' generally refers to the right of the occupation to regulate its own activities, or the:"...collective capability of members of an occupation to preserve unique authority in the definition, conduct and evaluation of their work and also to determine the conditions of entry to and exit from practice with occupational parameters" (Child and Fulk 1982, p.155). The concept 'power' is used as a relational term which refers to a dominance-subordination structural relationship in which one group can force another group to do what it wants the subordinated group to do (Krause 1977, p. 225). Since all occupational control in the health care market rests directly or indirectly on state legitimacy, power is to be understood as a three-corned or 'tripartite' relationship between the state, the medical profession and the paramedical occupations (Larkin 1983, p. 21). The meaning of 'state' refers to the: "total domain of official public action rather than as the government in the narrow sense"

(Child and Fulk 1982, p.172). The state then may include government administrative departments, bureaus, boards and standing or special committees established by the government.

CHAPTER III: LEGISLATIVE CONTEXT

A. INTRODUCTION

Generally speaking, this study examines the legal privileges and restrictions of two paramedical occupations in the province of Alberta in 1988. The focus on the provincial context is vital since within Canadian society, it is the individual provinces that are initially responsible for health and labour. However, over time the federal government has bartered with the provinces for some governing rights in the area of social welfare, in order to set national standards and to establish equitable funding. Nowhere is this division of responsibility illustrated more clearly than in the change in funding arrangements of health programs.

The provinces establish a legal foundation in order to carry out these responsibilities in the form of administrative law. This type of law contains two types of terms which I refer to as specific and enabling terms. Specific terms may create an agency or position which is empowered to act on behalf of the state. Enabling terms then outline the jurisdiction within which the designated agency or position has been given administrative of governing authority. The latter 'enables' the delegated body or person to use the power of the state in specified ways. In other words, administrative law is one of the vehicles through which the state's power is distributed and exercised. It is administrative law that defines the privileges and restrictions of health care occupations including the paramedicals as found in government legislation. The provincial government and their agencies also publish other formal documents that further detail the activities of the various agencies. These formal documents provide the data for this study.

The purpose of this chapter is to clarify the significance of administrative law, to outline some of the most significant changes in broader health care legislation and to briefly introduce the paramedical occupations selected for inclusion in the study. The emphasis here is to highlight the formal aspects of the occupations' activities including the names of some associated acts and agencies.

B. THE PROVINCIAL CONTEXT

Canada is governed politically as a federated state consisting of a central government and ten provinces whose division of rights and responsibilities were defined originally in the **British North America Act**. Provinces have been given the governing responsibility for labor and health, both of which affect health care occupations. With regard to health however, the introduction of a health care insurance scheme, 'Medicare', by the federal government in the late 1960's established the basic principles of health care funding and delivery. The administration of this system is left to the provinces. This situation creates continual interaction of responsibility between the two levels of government and nowhere is this tug-of-war seen more clearly than in their concern over the cost of health care and the question as to which government level is or is not, carrying its fair share.

Throughout the history of Medicare one can see the changing assumptions of the cost burden of health care being translated into legislation of the health care system. Evans (1985, p. 440) suggests that until 1970 increased cost was viewed as acceptable by the federal government; since then, it has not been accepted . Consequently, the federal government has changed Medicare legislation to stabilize its share of the cost, while forcing the provincial governments to bear any extra increasing costs. Specifically, in 1977, the Federal-Provincial Arrangements and Established Programs Financing Act was passed by the federal government. This act changed the basis of funding of hospital and medical services from a fifty/fifty basis with the provinces, to block funding based on a certain percentage of the G.N.P. and per capita calculations (Dunlop 1988, p. 971). While this change was claimed to give the provinces more flexibility in establishing different mixes of health care services, it could be seen by the provinces as passing on increasing costs to their treasuries (Premier's Commission:Final Report Vol.III 1989, p. 69).

Furthermore, Evans maintains that a system of health care insurance such as Medicare, will not change the established structure of the system which at the time Medicare was introduced was based on a physician-dominated, hospital-based type of delivery. Within this type of delivery system and insurance funding, an emphasis on increased efficiency could stimulate two methods of change, one which would attack the unit costs directly or another which would change the mix of services. But Evans (1978, p. 203) concludes, any increasing use of alternative services provided by paramedicals would challenge the earning levels of existing professionals . The provincial governments, given this flexibility due to the change in funding, could conceivably change the mix of health care services. But the Alberta government and the physicians instead have concluded that the system, as it was structured, was underfunded. Consequently, hospital user fees and extra-billing were introduced in Alberta.

According to Brown (1986, p. 125), it was the Alberta government's change in legislation to allow hospital user fees and the fear that such a precedence would set, that prompted the federal government to enact **The Canada Health**

Act in 1984 . This legislation which withholds federal funding on a dollar for dollar basis equal to that charged to the patient either as extra-billing or hospital-user fees, was viewed by the federal government as a necessary safeguard of the principles of Medicare (Brown 1986, p. 127). But the provinces may view this change as federal interference or more specifically as:"...the federal government legislating federal standards that provinces must follow but not backing this up with the necessary funding to permit the province to follow without increasing their costs". This report continues to say that as costs rise the provincial government will have to make "different choices" which are seen as either passing on the costs to patients or to rationing services (Premier's Commission:Final Report 1989, p. 69). Therefore the option of changing the mix of services may not appear to be seen as a viable one to the Alberta government.

The Alberta government's seeming lack of willingness to change the mix of health care services, does not mean it has ignored legislation of occupations in general, and of health care occupations in particular. **Report II on Professions and Occupations (December 1973)**, also known as the Chichak Report, asserts that the "knowledge explosion" has affected "existing professions and occupations" and will create new ones. This report (1983 p.3)also suggests that in the public interest, more professions and occupations will have to come under some type of legislation: this includes "paraprofessionals and technicians" upon which the currently legislated professions and occupations are becoming more dependent.

The recommendations of the Chichak Committee suggest: that a profession and occupation must be licensed and that legislation must include the qualifications needed to obtain a license (recommendation 5, p. 20); that there be an "umbrella act" developed to cover many professions and occupations (recommendation 25, p. 22); that all new legislation or amendments to existing legislation be handled by one minister (recommendation 22, p. 21); that a Council of Professions and Occupations be established to "review, assess and make recommendations" to the Minister on new or existing legislation (recommendation 23, p. 21); and that the Minister may call on this council to carry out activities or make requests regarding the "scrutinizing, examining of existing and prospective statutes" (recommendation 24b, p. 22) among other things. Interestingly, while these recommendations were to be applied to all occupations and professions, they have only been fully implemented with regard to health care occupations with the development of **The Health Disciplines Act** and the Health Disciplines Board in 1982 and the Professions and Occupations Bureau.

More specifically, within Alberta in 1988, there were four different routes through which a health occupation could conceivably be legislated: **The Societies Act, The Professional and Occupational Associations Registration Act, The Health Disciplines Act** or the occupation's own unique Act labelled by its occupational name. One might expect that health occupations could be legislated and administrated along any of these routes. However, terms within two of these Acts specifically deny health occupations the right to be legislated under them. Subsection 3 (2) of the **Societies Act** states that if another Act provides for incorporation of the association, it is not allowed to be incorporated under it. Subsection 5 (a) of the **Professional and Occupational Associations Registration Act** more explicitly says that: "...a health occupation designated or eligible to be legislated under the **Health Disciplines Act**..." cannot be legislated and administrated under the former act.

Two of the routes listed are legally closed to health occupations, as the Alberta government legislates health occupations more specifically than other occupations. So while the Alberta government has created many and diverse ways to legislate and administer associations generally, it restricts the route options for health care occupations. Moreover, the route is prescribed by law, not chosen by the occupation.

Within the Canadian societal context then, provincial governments legislate paramedical occupations' corporate activities; in addition, they legislate and fund their work institutions, programs and services. And they can set up state agencies with both governing and administrative rights to carry out provincial responsibilities. That is, the provincial governments of Canada have diverse ways of establishing its power over health occupations and their services. One must therefore examine a wide range of government documents in addition to occupational Acts and Regulations.

C. FORM OF LEGISLATION

The provincial legislative documents used in this study come under the heading of administrative law, as opposed to criminal or constitutional law (Cowan 1988, p. 14). Within Canada, law is generally divided between procedural law and substantive law; substantive law is further divided between private law which contains the legal rules concerning the settlement of disputes between individuals, and public law which contains the legal rules that structure individual or group rights versus those of the state. Within public law there is criminal, constitutional and administrative law (Faculty of Business 1988, p. 17). Generally speaking the specific and enabling terms within administrative law will initially create an administrative agency, which then may pass more legislation in the form of regulations. The courts may deal with these agencies only when they have exceeded their legislated powers (Faculty of Business 1988, p. 17). More specifically, this type of law establishes the jurisdiction within which these administrative agencies may act, the procedures they must follow and any right of appeal an individual may have to the agency's decisions (Cowan 1988, p. 14). The courts can only pass judgement on the basis of the terms of the legislation concerning whether an agency exceeded its jurisdiction of authority, did not follow stipulated procedures or committed an error in its interpretation of the terms of the legislation (Cowan 1988, p. 15). Common law applies only where no formal law exists (Cowan 1988, p. 12).

Coincidentally, the modern state is seen to be increasing its legislation in welfare and economic areas, and since the state is not able to pass terms of legislation to cover all aspects of its increased activities, many of the Acts it passes contain terms that enable these government established administrative agencies to formulate the regulations needed to establish and administer these state activities (Cowan 1988, p. 14). In addition, about one third of all agency regulations are formal and become part of administrative law. These formal regulations are passed by the Lieutenant Governor in Council at the provincial level of government (Forsey 1988, p. 1584).

Currently then, the initial legislation or Acts often contain not only the terms needed to set up administrative agencies but also the enabling terms allowing the agencies themselves to initiate their own regulations, many of which become formal law when they are passed by the Lieutenant Governor in Council. The terms within the Acts and the accompanying Regulations form the basis of administrative law.

There are three main types of government administration agencies that operate in this manner: self-governing agencies such as professions which control their own activities; regular government agencies that are headed by a minister of the government; and independent agencies such as crown corporations (Janish 1988, p. 1847). Self regulating bodies, composed of an occupation's own members, are usually able to determine their own occupational credentials and code of ethics and to administer their own register. Government agencies have many different responsibilities and their members are appointed by the government (Janish 1988, p. 1847). At the provincial level, there has been a great increase in the number of individuals working within agencies due to the need to administer an increasing number of provincial services, especially welfare services (Ruff 1988, p. 1776). Some government agencies are seen to be becoming so powerful that they are said to be overtaking the responsibility of the minister that oversees them (Gow 1988,

p. 916). But none of the agencies are independent in an absolute sense given that they must operate within the terms of their legislated Acts and Regulations.

The interest of the Alberta government in this type of law can be seen in the 1974 **Report of the Select Committee on the Legislative Assembly on Regulations in the Province of Alberta**, also known as the Zander Report. The Zander Committee was established to investigate, to invite public input and to make recommendations with regard to Alberta regulations (Government of Alberta 1974, p. 1). Its first recommendation was for a "more complete and all-encompassing definition of regulations" (recommendation 1, p. i) and then for those who draft or interpret "regulation-making empowering clauses" to be familiar with the principles of this type of legislation (recommendation 7, p. i).

The description in this study is primarily based on documents of administrative law. The terms within this area of law specify the jurisdiction, proceedings and interpretations of the activities of administrative agencies of the state, including corporate professional associations. Common law does not apply where administrative law exists and the courts, when involved, can only follow the terms within the enacted legislation. Professional bodies and government administrative agencies are the types of agencies basic to this study. Government agencies are seen to be expanding and becoming more powerful due to increased government activities concerning welfare responsibilities. Much of this expansion can be seen at the provincial level of government, especially as it relates to health care and will be found in formal documents. The number of possible provincial documents is delimited by examining the occupational control and power relations of just two paramedicals for one year.

D. PHYSICAL THERAPY AND RESPIRATORY THERAPY

Before proceeding to the methodology chapter and a discussion of how the formal documents are used in the study, a brief description of the two selected occupations, as corporate bodies, can be ascertained from other less formal documents. The defining features of Physical Therapy and Respiratory Therapy, as corporate entities, are conveyed to the public in the form of pamphlets. In this section, unless otherwise specified, the source used is the occupation's pamphlet; in the case of Respiratory Therapy the pamphlet is titled "The Role of the Respiratory Therapist", and in the case of Physical Therapy the pamphlet is titled "College of Physical Therapists of Alberta".

Physical Therapy's work activities are described as:"...the assessment, treatment and prevention of problems relating to the musculo-skeletal, respiratory and neurological functions." The pamphlet advises that physical therapists may work in a variety of regular work settings which range from hospitals, rehabilitation units, home and community care, and private clinics in addition to industry and sports work settings. But it also stresses that in all cases, the patient must be referred to a Physical Therapist (hereafter referred to as P.T.) by a physician. However, physicians, in a pamphlet of their own, state that they would prefer greater medical direction and assessment of physical therapy services (CMA Committee on Allied Health 1986, p. 43).

In 1988, there were 1115 registered and licensed Physical Therapists working in Alberta which represented a member: population ratio of 1:2,148. Of this number, 39% were employed by hospitals and 37% practised in private clinics (Health and Social Services Disciplines Committee 1986, p. 136).

P.T. membership at the national level is based on a national examination (CMA Committee on Allied Health 1986, p. 35). The curriculum follows guidelines established by the Canadian Physiotherapy Association and its training programs are accredited by a committee appointed by the national body. It includes three physiotherapists, one educator and one physician (CMA Committee on Allied Health 1986, p. 35). The national physical therapy association apparently has a great deal of control over its own curriculum and training standards. In order to practice in Canada, physical therapists must be eligible for membership in the national Canadian Physiotherapy Association but this only entitles a practitioner to apply for a provincial license (CMA Committee on Allied Health 1986, p. 35).

Physical Therapists in Alberta are legislated under **The Physical Therapy Profession Act** which came into force in 1985. Previous to that they were legislated under **The Chartered Physiotherapists Act** (Health and Social Services Disciplines Committee 1989, p. 136). In 1988, the main corporate bodies included the Alberta Physiotherapy Association and the College of Physical Therapists of Alberta (Health and Social Services Disciplines Committee 1989, p. 137). The College, which consists of all physical therapists practising in Alberta, is responsible for the administration of their occupational act. More specifically according to their pamphlet, it sets the provincial P.T. educational and clinical requirements as well as the code of ethics and it enforces them. The College is also the licensing and registration authority in the province (Health and Social Services Disciplines Committee 1989, p. 137). In order to practice in Alberta a prospective physical therapist must obtain a license and membership in the College of Physical Therapists of Alberta. Currently, physical therapists are graduates from a four year degree program with a BSc.P.T.. And according to the occupation's public literature, physical therapy claims to have control over who gets licensed to work within this province.

Respiratory Therapy (hereafter called R.T.) is described as:"... the scientific application of therapy in order to assist the physician in the diagnosis, treatment and promotion of well being of the patient with respiratory and associated disorders." Generally speaking, the responsibilities of R.T. include: therapeutic, diagnostic, technical, educational, administrative and research services. In practice, their members are required to understand the therapeutic objectives of the prescribed techniques, to help in their selection, to apply them and to assess their effectiveness. Whereas, physicians acknowledge their dependence on R.T.s and would allow them to be responsible for operating the equipment, they insist that physicians must provide direct supervision of R.T. services (CMA Committee of Allied Health 19886, p. 154). Although Respiratory Therapists are primarily employed within hospitals, they see themselves as having the necessary education to work in home care and industrial settings providing such services as environmental pollution monitoring and consultative services.

In 1988, there were 478 registered members. This represents a 1:5,010 ratio between members and the population (Health and Social Services Disciplines Committee 1989, p. 203).

Membership at the national level requires that a prospective respiratory therapist have graduated from an accredited education program and have passed the examination of the Canadian Society of Respiratory Therapists. The examination is prepared and administered by a joint committee on respiratory therapy of the Canadian Anaesthetists Society and the Canada Thoracic Society. In 1986, the education committee of the Canadian Society of Respiratory Therapists established curriculum guidelines for training programs but it should be noted that approved schools must designate a medical director to provide medical input (CMA Committee on Allied Health 1986, p. 149). The national body of R.T.s relies on medical co-operation in establishing its national exams and curriculum. Even the pamphlet entitled 'The Role of the Respiratory Therapist' received approval of the Canadian Anaesthetists' Society and the Canadian Thoracic Society as well as the Canadian Society of Respiratory Therapists.

Within Alberta, Respiratory Therapy has been legislated under the Health Disciplines Act since 1986. The two main corporate bodies are the Alberta Association of Respiratory Therapists and the Respiratory Therapy Committee. At the provincial level, education qualifications are set by the Health Disciplines Board (Health and Social Services Disciplines Committee 1989, p. 204). The Health Disciplines Board has approved two Alberta programs and all other programs in Canada, that have been previously accredited by the joint national Canadian Society of Respiratory Therapists/Canadian Medical Association committee. The Health Disciplines Board has also recognized the examination offered by the national C.S.R.T.. However, it is the R.T. Committee and the Health Disciplines Board that register and discipline members in Alberta (Health and Social Services Disciplines Committee 1989, p. 204). In Alberta, the provincial association then is responsible to the Health Disciplines Board which currently relies on the national examinations and curriculum standards which are set jointly by the national R.T. society and medicine. An occupational committee, in cooperation with the Board, administers their register. It would seem that R.T. within Alberta, cooperates with a government agency in order to administer its register and views itself as cooperating with medicine on other aspects of its occupational activities.

E. SUMMARY

The substance of this chapter emphasized the significance of the legislative context for understanding the formal basis of occupational control. The names of some of the most important acts, agencies and documents were introduced in order to describe, in a preliminary way, the occupations of Physical Therapy and Respiratory Therapy. In the next chapter, the methodology of using formal documents is discussed.

CHAPTER IV: METHODOLOGY

A. INTRODUCTION

The research strategy of this study may be described as a comparative case study since it attempts to describe and compare the formal control which R.T. and P.T. have gained through legislation. This research topic is, according to Yin 1984, p.13), a contemporary phenomena over which the investigator has no control. Accordingly then, it would not be appropriate to apply a historical or experimental strategy. The evidence for this study is from formal government documents analyzed in a qualitative manner. The volume of required documents is restricted by the fact that the study focuses on the corporate bodies and agencies of two paramedical occupations, medicine and the Alberta government, as of 1988. The documents were selected from an updated government publication containing a complete listing of documents in effect for 1988. The detail contained within the documents was coded and sorted in a systematic way using a manual system consisting of 5 by 3 cards. Having separated the detail onto cards, it was then recombined in a specified way in order to describe and to analyze the data from a sociological perspective.

To ensure a sociological analysis of the documents, it was necessary to first develop a theoretical framework of occupational control. This framework was developed initially from the literature by extracting what appeared to be separate dimensions or categories of control. Where subcategories or properties within dimensions were noted, they were also extracted and made part of the framework (Glaser and Strauss 1967, p.36). The framework then became the basis of document collection, data management and data analysis. That is the framework was modified by the discovery of unanticipated categories and properties found in the documents. The resultant product then became the basis for the comparison across the two occupations. The analysis was derived in this manner to improve both the credibility and the completeness of the findings.

Freidson's interest in occupational control and power has been continuous but his research strategy for studying the topic has changed. His work illustrates the change from focusing on the medical profession as the ideal profession (1970a, p. xvii) and theoretically generalizing to other professions by means of a highly abstract concept (1970, p. xix) and by using only secondary data to support his arguments to viewing professions as occupations with common credentials that are prerequisites for a job (1986a, p. xii), seeing the professions themselves as neither dominant nor impotent (1986a, p. xiv) and viewing them as being historically specific (1986a, p. xii). As he wrote recently: "The strategy of analysis, is therefore particular rather than general, studying occupations as individual empirical cases, rather than specimens of some more general fixed concept" (Freidson, 1983, p. 34/35). (my emphasis)

Since this study follows the authors looking at the formal, not informal, aspects of occupational control, the data is sought in libraries containing government documents, not in field observations or interviews. Given the complexities and different forms of the formal privileges of paramedicals and the aim to describe them while not dealing with intent, government documents are both valid and reliable. They are valid in the sense that government documents themselves provide direct evidence and therefore have face or content validity for the description of formal occupational control and power relations since one does not have to infer intent or informal control from them (Bailey, 1978, p. 288) and reliable in that these documents form a permanent set of data that survives intact and without deterioration or loss (Bailey, 1978, p. 290).

Other authors have addressed this issue in this way. Freidson (1986a, p. 227) concludes, that in order to describe an occupation's control one should examine documents such as the legislation of the occupation and the rules of its related institutions, especially its work institution. More specifically, with regard to the health system in the United States, Freidson (1986b, p.67) denies that any significant change has occurred since the licensing of the medical profession, and consequently he continues to assert that medicine retains its legally enforced monopoly over key functions of health care (1986b, p. 70). He concedes competitors may have made some inroads in medicine's monopoly but that "every road has been carefully limited by law" (1986b, p. 70). The basis of these assumptions could be found in legal documents as well.

Taylor (1960) states that sociologists and political scientists, are interested in the power of organized groups and by utilizing documents such as legislation as a data base, he describes the power of the medical profession in Canada. Other authors have used the same type of documents to describe the historical power patterns of the medical profession in Great Britain and the United States (Berlant 1975) and of different patterns of paramedical occupational power in Great Britain (Larkin 1983).

B. RESEARCH DESIGN

Given the volume of documents available, the study is designed to initially restrict them in a systematic way. The purpose of this study is to describe how the legal privileges and restrictions of a paramedical occupation structures them into the health economic and political marketplace. The study does not address the intent of the actions of any of the groups. Therefore formal government documents, not occupational journals or newspaper articles, are the basis of this description. Larkin (1983), Hamowy (1984) and Taylor (1960) among others include data from occupational journals and other publications for their studies since they include an assessment of intent.

A further systematic restriction is due to the unit of analysis specified, which in this study is that of the corporate group (Yin 1984, p. 33). This unit is shown by the wording of the research questions (Yin 1984, p.31). The study does not focus on the individual members of the groups involved. When the term 'member' is used, it refers to representatives of their respective groups. This approach generally follows the work of Alford (1975), Taylor (1960), Gilb (1966) and Larkin (1983) and not the more historical type of manuscripts that focus on the contribution important members have made (Hamowy 1984) nor of some aspects of Freidson (1986a) where he includes the possibility of prominent individual members appearing before important committees. This study is not historical and the contributions that prominent individuals may add, are not included. Nor does the study focus on anything but the very public, non technical, politically initiated Royal Commissions found in Canada, to which individuals are appointed primarily as representatives of their respective groups. It is representatives of the corporate associations of occupations which submit the views of the occupation to the commissions. Furthermore, the focus is on the corporate bodies and agencies of occupations and government found within the society, and not on the society itself. These specifications restrict the library documents to be searched to those of the corporations involved and not the personal diaries or papers of individuals.

In order to more specifically establish the limits of evidence needed, the boundaries of this study (Yin 1984, p. 42] are geographically set within the province of Alberta in 1988 and restricted to two paramedicals, Respiratory Therapy and Physical Therapy. The year 1988 was chosen primarily because of the timing of the study but fortuitously it was also a year of much specification and activity in the structuring of the health care system, including the calling of a provincial Royal Commission on the future of health care within the province. Given the time lag in the completion of the study, it has been possible to obtain the complete collection of documents including the results of the provincial Royal Commission (The Rainbow Report) and the annual reports which are not available until the following the year reported. Therefore, the study consists of a complete set of data on a relatively current situation.

Respiratory Therapy and Physical Therapy were chosen because they were legislated under two different formal legislative routes: **The Health Disciplines Act** and **The Physical Therapy Profession Act**. Yet, these occupations were the most similar representatives of occupations legislated under the omnibus act or a unique paramedical occupational act. That is, they both primarily provide therapeutic not diagnostic services with some of these services overlapping in some types of diseases, such as chest conditions. The services of both R.T. and P.T. are especially important in the care of the increasing number of chronically ill patients. They have been ranked within 1-3 points on a 41 point prestige scale by patients, physicians and students (Shortell 1974, p. 4) and recently, in the United States were within a difference of 1% of female/male ratios, both being predominantly female (Butter, Carpenter, Kay and Simmons 1987, p. 141). And R.T. and P.T. are the two paramedical occupations which some medical sociologists predict will overcome medical dominance (Twaddle and Hessler 1987, p. 236).

The study then analyzes the occupational control and current patterns of power of two quite similar paramedical occupations predicted as the ones most likely to gain important control. But it also provides for a comparison between two paramedical occupations which although similar, have the formal control of their activities structured differently. In terms of Glaser and Strauss (1967, p. 55) a study of these similar comparative groups should illustrate important maximum comparisons of formal occupational control. This comparison of the power patterns of somewhat similar groups could then form the basis of substantive grounded theory (Glaser and Strauss 1967, p. 23). That is, in the terms of Glaser & Strauss (1967, p. 56-57) by minimizing differences within comparative groups one can establish a framework of basic categories and their properties, prior to minimizing and maximizing differences among different types of comparison groups to stimulate more formal theory.

The development, refinement and use of a theoretical framework aided in every aspect of the conducting of this study. It initially identified relevant aspects (categories or dimensions) of occupational control and it aided in the initial collection of documents. It was then refined into more well defined dimensions and interrelationships with explicit detail (properties) within each. And this theoretical framework of dimensions of control and power relations covered every aspect of the occupation's activities. Each dimension was examined for the occupation's control of that discrete aspect of occupational activities and then for any restrictions due to its power relationships with medicine and/or the state. The degree and form of occupational control could be described by the way it varies along each dimension, between dimensions and between levels. The variations thus form patterns.

The development of the framework and a review of the literature from which it is derived is discussed in Chapter V. The discussion of the framework in this chapter centers on the role the framework played in the design of the study.

Figure 1 contains one of the earliest versions of the framework. At this point in its development, the two levels of dimensions of control had been identified. Most of the dimensions had also been identified and labelled but they were refined at a later point based on the substantive material found in the documents being reviewed.

Figure 1

A FRAMEWORK OF PARAMEDICAL OCCUPATIONAL CONTROL:EARLY VERSION

I: Dimensions of Control Within the Medical Marketplace

- (a) right to title
- (b) scope of practice
- (c) gatekeeping rights
- (d) domain of work
- (e) income structure
- (f) occupational credentials
- (g) code of ethics

II: Dimensions of Control Over the Marketplace

- (a) registry location
- (b) quasi-legal administrative apparatus
  - i. register administration
  - ii. governmental administrations of health system as it relates to health occupations and their services
- (c) government structure for administrative co-ordination.
- (d) government administrative apparatus to initiate and\or resolve broader change

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The end result of using this framework is to organise the data along the specified dimensions and to combine them in a sociological and theoretically based manner. The data is used as evidence for an analytical description of an occupation's formal pattern of power or position in the health care division of labour and institutional framework and for conclusions as to whether the occupation has secured a monopoly over any aspect of its activities. The final role of the framework then is to structure the detail into sociologically meaningful units which then can be used in replicating the study across occupations in order to refine it or for analytical descriptions. That is, in Yin's (1967, p.38) terminology the framework has external validity to theory and to other cases.

The development of a conceptual framework from the literature on professions was a way of dealing with the complexity of the detail found within the terms of the documents. It was also a device to ensure that the examination of the documents was done methodically and rigorously. Finally, it was a way to overcome a limitation of using administrative data, namely having results that are administratively but not sociologically relevant. Freidson (1983, p. 219) has suggested that sociology can overcome the limitation of working with administrative data by using its own methods of data collection and its own methods of data analysis based on sociological theory. The development of the conceptual framework from the literature on professions was an attempt to ensure that a sociological analysis would be obtained from administrative documents.

The use of the term 'framework' here very much follows Yin's (1984, p. 40) idea of using what he calls a 'case study protocol' in order to increase the reliability of this type of study . Yin (1984, p. 64) includes within this term both the questions or prompts the investigator must keep in mind when examining the data and the procedures surrounding the collection of data . In this study the protocol primarily refers to questions needed to guide the search of the document detail. Then by using these prompts, the corresponding terms found within the documents further refined the framework of dimensions (categories), their related properties and their interactions (Glaser and Strauss 1967, p. 36). The possible further use of these categories by other researchers may, according to Bailey (1978, p. 290), overcome the lack of consensus on specified categories thereby possibly increasing inter-analyst reliability (Bailey 1978, p. 290). The idea of using a protocol will also increase the reliability or repeatability of the study (Yin 1984, p. 40). The more specified framework of patterns of interrelated dimensions (categories) and properties also provides for the possible pattern matching of detail within one occupation and the replication logic in comparing the detail across occupations (Yin 1984, p.38).

But most basically, the use of an understandable framework is to allow the reader to eventually judge the credibility of the description (Glaser and Strauss 1967, p. 228).

This study then employs a case study research strategy using government documents as its data source. Initially a tentative framework was developed from the literature on professions to collect the documents and to be used as an instrument to initially examine the detail within the documents, with a view to refining and clarifying the categories and properties in the framework. A more specified conceptual framework of categories, their properties and relationships emerged. Then an analytic description of the occupations was undertaken based on the resultant framework to show the complexity and forms of the different patterns and to address the original questions of the study.

C. DATA COLLECTION

For this study the first step is to decide which documents to collect given the questions of occupational control and power relations. As was described earlier, the unit of analysis and the study boundaries initially limited these documents to 1988 and to the Alberta provincial government documents relating to R.T. and P.T.. One advantage of this restriction is that most of the documents could be retrieved at one location, the Queen's Printer, while others arrived by mail after a phone call to the appropriate agency. The key advantage of using these types of documents over other types is that they are public not classified or restricted, and therefore readily accessible. They are also accurate and detailed (Glaser and Strauss 1967, p. 180).

With regard to the actual collection procedures used, the Province of Alberta's Queen's Printer publishes a yearly publication catalogue which lists all the current Acts, Regulations and Amendments, in addition to other government publications. This catalogue provides a complete listing of provincial government legislation in effect for a given year. The legislation is collated alphabetically and states which department or individual is responsible for the administration of a particular Act or Regulation. The catalogues are free and available on request. The Legislative Library and the Government Publications Library at the University of Alberta have the legislation dating back to 1905. If the Queen's Printer is used as the source, the documents requested will include any amendments to the Act or Regulation. The complete list of documents gathered is contained in an appendix. (See Appendix: List of Government Documents).

D. DATA MANAGEMENT

Some have argued that documents themselves provide an incomplete account of an event and are limited to verbal behaviour since they often do not provide a context (Bailey 1978, p.269/70). Documents for this study do not need to include nonverbal behaviour since their terms are the formal basis of occupational privileges and restrictions, they are not a symbol for it. Furthermore, according to Bailey (1978, p. 270-71), documents generally lack standard formats, present coding difficulties and the data may need to be adjusted for comparability over time. Again this criticism does not apply to this study because the documents used have a standard format and the restriction of the study to one year eliminates any potential problem due to change in format.

Coding difficulties are a problem but these documents are still superior to most types of documents in this respect. The language used within them follows very common usage; only the phrases 'notwithstanding' and 'pursuant to' are out of the ordinary. There are no Latin or professional legalistic technical terms used. The document provides primary, not secondary data, for the questions asked in this study since formal privileges and restrictions are defined by the terms found within them (Bailey 1978, p.266). Terms within the acts and regulations can therefore be used as direct evidence of an occupation's control or formal pattern of power. Annual and commission reports are also seen as primary evidence of the committee's or commission's activities. Alford (1975, p. 24) classifies these reports as "outputs" of organizational activities. In the case of annual reports, the document is a self-reported account of the agency's activities which can provide new or reinforcing evidence found in the documents.

In terms of coding, the data itself must be collected from the documents to be used as evidence for the study (Yin 1984, p. 89). It is Yin's (1984, p. 96) contention therefore, that a "chain of evidence" must be maintained to increase the reliability of the information used. That is, specified steps of collecting the evidence must be followed so that none of the evidence collected during the data collection phase is lost due to carelessness or bias, and so that the procedure could be replicated. It is this chain of evidence which guides the development of a sufficient data base to be used as evidence in citations; and links the research questions to the study conclusions.

A specific chain of evidence for obtaining the data was followed. After the collection of the documents, each document was read in full and the actual detail within it was printed on cards as suggested by Glaser and Strauss (1967, p. 106). This first reading of the data was also the first sorting for relevance. Materials judged to be irrelevant to this study were not transferred to cards. For example, some very specific terms that were present for legislative administrative purposes was eliminated. With regard to the annual and commission reports, the detail collected closely followed Alford's (1975) methodology and this eliminated much non-essential detail. For example, the repetitive discussions surrounding the report recommendations were not transferred to cards.

Each card contained only one section of a document, properly labelled to indicate the source. This method of recording the data is especially effective in not only separating out the detail but also incorporating changes in the wording which is not contained in the most recent office consolidation of the Queen's Printer. That is, often the Acts and Regulations have Amendments accompanying them. There are therefore, two different pieces of legislation with one amending the other. These changes can be written onto the cards so that this change in detail is incorporated thus rendering them currently accurate. Also if one section refers to another section by number, information from that section can be cross referenced on two or more cards. Thus the detail recorded on each card is complete. The cards containing separated and singular details can then be arranged and rearranged into 'chunks' of information according to the sociological framework of occupational control.

Figure 2 illustrates how the detail in the document was transferred to a card.

Figure 2

EXAMPLE OF A CARD

Health Disciplines Act: Office Consolidation p. 13
Part 3: Registration

s12: Eligibility for Registration
(1) Subject to subsection (2), a person is eligible to be registered to practice in a designated health discipline if that person:
(a) Meets the qualifications prescribed in the regulations
(b) Is of good character and reputation
(c) Has paid the fees prescribed in:
(i) the regulations, if the health disciplines is governed by a Committee, or
(ii)the by-laws, if the designated health discipline is governed by a health discipline association.

(1.1) Subject to subsection (2), a person maybe registered.....(continued).

To facilitate the sorting task and the rearrangement of the cards to the theoretical framework, further steps were introduced. The sections are usually accompanied by a title. Therefore, the section numbers were listed on a separate piece of paper in their original sequence, along with the relevant title. These sections were then coded to correspond to the relevant dimensions of the framework.

This procedure can be seen by referring to the legend and the left margin in Figure 3. The legend contains symbols which stand for dimensions of the framework. The symbols are coded for each section number and title in square brackets on the left margin.

Figure 3

CHAIN OF EVIDENCE FROM ONE PIECE OF LEGISLATION: SELECTED SECTIONS

Health Disciplines Act: Part 3: Registration

[1/2] Section 8: Registrar and Personnel
[1/2] Section 9: Power of Registrar
[2] Section 10: Investigation
[2] Section 11: Register
[3] Section 12: Eligibility for Registration
[1] Section 13: Registration
[2] Section 14: Review of Application
[2] Section 15: Refusal of Application
[3] Section 16: Annual Renewal/ Cancellation of Registration
[2] Section 17: Cancellation of Registration with

Legend
[1] register management
[2] register administration
[3] occupational credentials

This sheet served as a method of retrieval. It allowed one to efficiently and accurately retrieve the discrete pieces of information that had been reproduced on cards. By scanning the symbols down the left margin (again refer to figure 3) it was possible to locate all the cards related to a given dimension of the framework.

One more procedure was introduced in constructing the chain of evidence. Because the information stored on the cards could pertain to two or more dimensions in the theoretical framework, it was necessary to have the cards cross-referenced in a more direct way. Therefore, the information from the sheet of paper (illustrated in Figure 3) was reorganized according to the elements of the theoretical framework.

The product of this procedure is shown in Figure 4. "Occupational Credentials" is one of the dimension in Level I of the theoretical framework.

Figure 4

EVIDENCE FOR OCCUPATIONAL CREDENTIALS (FROM LEGISLATION)

Health Disciplines Act
  Sections
    12: Eligibility for Registration
    16: Annual Renewal/Cancellation of Registration

    27: Regulations

  Subsections of Section 27
    (1) The Board may pass regulations
      (c) qualifications/eligibility for registration
      (h) training programs for applicants
      (i) exams to determine eligibility
      (k) prescribe conditions for renewal
      (l) training programs/exams if failed to maintain competence

Respiratory Therapy Regulation
  Sections

  Subsections

Arranged under the title occupational credentials are all the relevant pieces of information from the documents. This system allowed me to handle a large and complex data set. It allowed me to arrange the relevant information for any given element of the framework at a given moment and then to re-arrange it according to another element without losing any information and with a minimum of confusion.

The properly labelled card of the same title and section number, having been retrieved, was then examined to see if it or any of its subsections were truly applicable. This served as a cross-check on the initial coding. This method of listing all the relevant sections by their number and bits of information; and making inclusive lists of the sections and subsections of all possible pieces of legislation; and then examining every word and phrase on the card separately to see if it could conceivably be included under a dimension, allowed for the possibility of refining the framework. It also allowed for a second sort of the data by eliminating information that was not relevant to the topic being studied. Given the complexity range and volume of the data, this data management tactic of maintaining a specific chain of evidence from the legislative framework to the theoretical framework was necessary to deal with the documents in a methodical and rigorous way.

To summarize: First, the relevant information found in the documents was printed on cards, each card properly labelled and containing only one section or piece of information from the legislation or the reports. A shorthand listing of sections and subsections was done and coded according to its relevance to the dimension in the theoretical framework. Then the sections and subsections of the pertinent pieces of legislations were recombined and listed under the specific dimension. In this way the detail was separated from its legal framework of sections and realigned into a sociological theoretical framework of control dimensions. The related cards were then collected to conform to these lists and the detail found within them provided the basis for the description and for refining the framework. A similar chain of evidence was used to restructure the detail from government reports.

E. DATA ANALYSIS

Generally speaking, an analytical description is one in which a phenomenon is separated into its different parts or elements which then are recombined according to a plan in order to provide the basis for a written account of the topic being studied. The questions to be addressed in this analysis concern sociological interests of formal occupational control and power relationships and eventually the paramedical occupational structuring in the health care marketplace and the institutional framework. The detail in the government documents is initially separated into discrete sections of information and then recombined into a framework of detail based on the sociological concepts and theory of professions. Basically the analysis provides a description of the formal rights, restrictions and obligations the R.T. and P.T. held, as of 1988 in the province of Alberta.

Both Yin (1984, p. 143) and Glaser and Strauss (1967, p. 228) discuss the importance of presenting the analysis in such a way as to convey its credibility. Glaser and Strauss (1967, p. 230) state that in order to accomplish this, standard analytic procedures are needed, in addition to a constant comparative method of analysis. Again following Yin's (1984, p. 100) terminology, the reliability and validity of this type of study are increased by following the more specific analytic strategy of pattern matching. Yin (1984, p. 99) views pattern matching as matching the data to patterns of propositions. The specific analytic strategy of this study borrows from Yin's terminology but views pattern matching as an analytic method of utilizing the theoretical framework to structure the documentary evidence into an account of an occupation's formal rights, restrictions and responsibilities. The resultant description emphasized the configuration of control and the patterns of power, specific to each of the paramedicals studied.

It is hoped that a clear analytic description using a theoretical framework, would provide the basis for further comparisons. This hope is reinforced by Yin's (1984) claim that a specific analytic strategy of pattern matching would enhance its "replication logic" allowing for further comparisons of patterns in different studies. That is, standard analytic procedures such as pattern matching are needed within an analytic descriptive study to generate the replication logic needed to generalize the patterns from one case to another and from one study to another. Further comparisons or pattern matchings should also improve the specifications of the framework itself.

F. SUMMARY

In this chapter the methodological issues and procedures were discussed. Essentially, the study consists of a comparison of two case studies of formal occupational control. Acts, regulations and other official documents are the primary source. To ensure a sociological interpretation of the documents, it was necessary to develop a conceptual framework based on published works in the general area of professions and then refined by examining the detail in the documents. The development of this framework is the subject of the next chapter.

CHAPTER V: FRAMEWORK OF OCCUPATIONAL CONTROL

A. INTRODUCTION

The framework in its entirety encompasses dimensions of every aspect of an occupation's control; each dimension delineates a discrete aspect. For further clarity these dimensions have been divided into levels: Level I, which includes the dimensions of occupational control and power relationships within the economic marketplace and Level II, which includes the dimensions of the occupation's control and power relations within the entire political marketplace. Within each level the dimensions are further grouped into Part A of Level I, which reflects on the occupation's attempt to secure social closure of its membership and Part B of Level I, which reflects on the occupation's attempt to secure a monopoly of the supply of their occupational services. Part A of Level II focuses on administrative control aspects within the political marketplace. The dimensions range from administrative control or self-regulation of its own members to administrative control within the political marketplace. Part B focuses on the governing control of the members, their supply of services and of the administrative agencies, by different corporate bodies and agencies.

An occupation which has been granted formal occupational control in Level I has achieved closure of its membership and an occupational monopoly of the provision of a specified type of services. The occupation's control within Part A of Level I may range from: no control - to some control with restrictions vis-a-vis medicine and/or government - to closure of its members and within Part B: from no control - to some control with restrictions vis-a-vis medicine and/or government - to a monopoly of its supply of services. Within Level II, an occupation within Part A may have: no legal control of the administration of its members, or their services, probably since there is no formal administrative apparatus in place - partial control with restrictions due to the structural embeddedness of the medical profession and/or the state within the administrative apparatus - full occupational control with self-regulation of its members and their services. Within Part B, the occupation may have: no absolute control (governing rights) over any aspect of the framework - some conditional control over some aspect - self-governance. Self governance means that the occupation may establish on its own, the terms of control for all or some aspects of its occupational interests ranging from control of its members, the supply of the occupation's services and the administrative apparatus.

The development of the framework started with a set of vaguely stated written ideas that were formulated in the course of reading and thinking about professions. These ideas were kept in a computer file. As the study progressed and I worked back and forth between the documents and the literature, the ideas were expanded and refined and the computer file was updated. An early schematic version of the framework was presented in the methodology chapter. Most of the elements (dimensions) were present in this early version. Although these were identified as categorical areas, the understanding of how an occupation's control or power relations was related to the categories was quite superficial. As a result of having worked intensively with the documents and having gone back and forth between the documents and the literature, the understanding of the framework was enriched. Figure 5 is a schematic representation of the final version of the framework. The text of this chapter is organized by and written with reference to Figure 5.

B. LEVEL I: DIMENSIONS OF CONTROL WITHIN THE ECONOMIC MARKETPLACE

Following Freidson (1986a, p. xii), Level I focuses on the credentialling of the occupation; that is on the legal rights and restrictions they have been granted. These features place each occupation into a unique occupational position within the heath care marketplace. It looks at two types of activities that the occupation must control, its membership and its supply of services.

Figure 5

FRAMEWORK OF OCCUPATIONAL CONTROL

Level I: Dimensions of Control Within the Economic Marketplace

A. Entitlement Conditions of/for Occupational Membership

- (a1) right to title
- (a2) occupational credentials
- (a3) code of ethics

B. Entitlement Rights of Supply of Services

- (b1) scope of services
- (b2) gatekeeping rights
- (b3) domain of work
- (b4) income structure

Level II: Dimensions of Control Within the Political Marketplace

A. Administering Rights

- (a1) register management
- (a2) register administration
- (a3) administrative responsibility by government
- (a4) administrative co-ordination by government
- (a5) administrative change by government

B. Governing Rights

- (b1) indirectly
  - by the legislature
  - by the lieutenant governor in council
  - by ministerial order

- (b2) directly
  - by occupational bylaw

A: Entitlement Conditions of/for Occupational Membership

(a1) right to title

Traditionally, health care occupations have sought legislation granting their members some legally defined and sanctioned exclusive title (and abbreviation) which will signify to the public their place within the health care field vis a vis other paramedicals and medicine (Hamowy 1984; McNab 1970). And more recently, they have sought to register their private practices with specified corporate names. Within the current Canadian societal context, it also signifies to the provincial government which legally identifiable group will receive further formal privileges such as payment for services delivered within health care institutions, programs or private practices.

A certified title serves only to identify occupationally registered members from other workers who may be providing similar services within the same occupational market. This certification may be endorsed by the association which on its own has few effective sanctions; or it may be endorsed by a state backed association which gives this endorsement more legal guarantees. In Alberta, government guaranteed association titles would come under the **Societies Act** or the **Professions and Associations Act.** Or finally, the government could guarantee a certified title within the terms of an occupational act. This route could provide the strongest sanctions backing the use of that certified title if so stated within the terms of the act. None of these types of support grant exclusive use of the title but the members may for example, call themselves 'certified physical therapists' to denote their position in the economic marketplace.

The greatest government backed control that the occupation may achieve over its title, is to be granted the exclusive right to use that particular title (and abbreviation) within the terms of its own act which would also specify severe legal sanctions for violations to be enforced by the courts. That is, the title itself is 'licensed'. Further occupational control would be achieved if the occupation itself and not some other group, specified the title and abbreviation to be used. And the title privileges would be more permanent if found within the terms of an Act, rather than a Regulation or By-law.

(a2) occupational credentials

To be able to practice under this title, a member of the occupation must first meet the occupation's credential requirements. These requirements become the criteria for applications and renewals of registration; i.e., register administration. Within one occupation, there can be various registers for members and a register of their practices. And there may be interactive requirements between the two types of registers. That is: What would happen to the member's business registration if the member does not continue to meet his occupational credentials for membership and he is subsequently removed from the member register?

Generally speaking, these formal member requirements fall into three categories: individual characteristics, educational credentials and fee requirements. Under all circumstances of admission and renewal, the members must meet these three conditions. Gross (1984, p. 103) maintains that the specified individual characteristics usually of minimum age, citizenship, language and residency are stipulated by the occupation to enhance its public image. It is the educational credentials that the occupation views as important barriers to registration and vital for the maintenance of certain levels of competency.

These educational credentials focus on the occupation's training program and training curriculum. Specifics of the occupation's training program concern such things as: the type of approved schools and whether there are different types - which can lead to the problem of multiple entry levels - and the minimum number of years required within each. Alternatively, there may be an apprenticeship program established with a specified number of years required to be completed under this instruction. In addition, there may be a work experience internship which would involve supervised practice of some kind. Finally, written and/or oral exams must be passed. The training curriculum is determined in the final analysis by which exams must be passed to get onto the register.

According to McNab (1970), a very important aspect of occupational control is to see if the individual who is applying, renewing or reapplying for placement on the register pays his fees to the professional association or to some other agency such as a government department. These fees, if paid to the association, allow the association to function independently. It is important to see who sets the level of fees. The terms for the occupational credentials are found within the occupation's act or regulations.

(a3) code of ethics

Ethical statements place the onus on the member of an occupation to act in a certain manner considered to be ethical or correct. A way of reinforcing all or some, of the control and power relations described on the other control dimensions may be found within code of ethic legislation. These statements then are not just rhetoric but are formally defined and formally sanctionable prescribed and proscribed, member actions. These terms become the basis for complaints laid against registered members by other members, their governing body, the government or patients. The importance of formal legally bound codes of ethics appears to be overlooked by the occupational theorists whereas classic theorists such as Parsons regard this as an informal code.

First of all, there may be general statements which reinforce member adherence to every term found in the occupation's Act, Regulations and By-laws. The terms found within the various forms of legislation may relate to inter-occupational competition on such service dimensions as scope and gate-keeping, to intra-occupational competition by such prescriptive terms as the advertising of private practices and to the members' competency and fitness to continually meet the occupation's credentials.

Furthermore, the legal terms of the 'code' itself can be stated directly within terms of the occupation's act or within the terms of its regulations or by-laws which are established through enabling terms of the act. These differences grant the occupation more or less control over the definition of these terms.

A pattern of great occupational control over its members would be one in which they are required to follow all the terms of the Act, Regulations and By-laws and could be charged with professional misconduct for any violation. A specified term may be one in which a competent member would treat patients only within the terms of their scope and gate-keeping privileges. The terms of the code would therefore reinforce these other terms. An enabling term within the Act may allow the occupation to initiate regulations for example, regarding the terms of ownership of their private practices and to pass by-laws that may allow the occupation to inspect specific work domains of their members.

This pattern grants the occupation important control over its members in that they are required to follow all these terms, some of which they can define themselves. If a member does not comply, he may be charged with unethical conduct and may be stricken off the occupational register. This would prevent him from working if registration is a mandatory condition for practising.

B: Entitlement Rights of Supply of Services

(b1) scope of practice

It is from the historical work on physicians by such authors as Hamowy (1984) and McNab (1970) that we come to see the importance of the range of services which the qualified, ethical and titled members of an occupation may legally perform. Larkin (1983, p. 183) especially criticized Freidson's concept 'autonomy' for its lack of specification of the range of services which the term may include. That is, dentists may have achieved Freidson's autonomy but only over a very restricted range of services. The terms of an occupation's legally defined range of services within the economic marketplace vis a vis other paramedical occupations and medicine, are to be found in the occupation's act or regulations and are viewed as an important step in controlling the supply of their type of services.

The terms may include such specifications as the type of diseases to be addressed, the method of treatment or the types of diagnosis they may encompass, the right to conduct research in their area of expertise and with the introduction of modern technology, the right to maintain their occupational equipment. And finally, with the rise of bureaucracies, terms might include the right to administer their own departments.

The terms themselves, may be very vague and definitional which allows the occupation to incorporate new technologies and services without changing the legal terms. This type of term is usually found within the occupational act. Or the terms can be very specific and hence, are usually found in regulations. Terms in the regulations may be changed more easily than those found in an act.

(b2) gatekeeping rights

While an occupation's scope of practice may stipulate the range of services that the occupation may provide, many paramedical occupations also have restrictions placed on their execution. That is, a service may be provided by the paramedicals only with the approval and/or supervision of physicians. Freidson (1977, p. 25), in his original definition of the term 'dominance', refers to these restrictions as medicine's right to diagnose and treat patients themselves or to prescribe and to evaluate the services provided by paramedicals. Thus, he views paramedicals as lacking the clinical autonomy that medicine enjoys.

However, as may be occurring more recently, gate-keeping may now include medicine's right only to refer the patient to a paramedical who then may further diagnose, prescribe, treat and evaluate his own services. Furthermore, Larkin (1983, p. 190) maintains that for paramedicals, this medical referral may grant paramedicals more occupational control than those who have full autonomy but who must operate outside the medically dominated marketplace such as chiropractors. Navarro (1988, p. 60) maintains that physical therapists in many U.S. states do not even have to have the patient referred to them by a physician. The terms of these gate-keeping rights or restrictions are found in the occupation's act or regulation often in conjunction with the terms of its scope of practice.

(b3) domain of work

The dimension 'domain of work' which focuses on the plant, equipment and supplies, as well as the occupation's services and their funding, is an especially important key for paramedicals. Much of the control seen on the previous dimensions is linked to securing work opportunities for the members. One becomes especially sensitized to this pattern when reading the literature on medicine's success on this dimension. That is, if only qualified, ethical and titled members, providing services within that occupation's defined scope and gate-keeping restrictions, may work in various health care institutions, programs and private practice which are also funded, that occupation has achieved significant occupational control.

It is from Fielding's and Portwood's (1980, p.45) work that one comes to understand the importance of describing the different work settings that may be created by government along with their specified conditions of work and their type of funding. This situation applies to the provincial health care markets in Canada as well as the markets in Britain. These terms then, are found not only within the occupation's act, regulations and by-laws but also within the legislation creating the work institutions, programs and private practices, in addition to terms of funding. For occupational control or subservience, the terms found within these different types of legislation can be reinforcing or negating (Larkin 1983, p. 7).

The relevant aspects of this dimension are sought by initially determining the types of domains in which paramedicals may work; institutions such as hospitals, programs such as home care, and private paramedical practices. And then one must determine if these domains are permitted to exist through a lack of specified prohibition within the terms of the various acts, regulations or occupational by-laws but employed by government health care agencies, or whether they are legislated by government (Fielding & Portwood 1980, p. 29). For example: Are paramedical private practices legislated or permitted (allowed) to exist but hired by the government to fulfil its health care commitments? And: Which occupational member is legally allowed to admit patients into these institutions, programs or practices? That is, does a physician, a government administrator or a paramedical member admit the patient?

Since most paramedical members expect to find work in hospitals whose physical plant may be government funded, it is essential to their occupational control that their particular services be specified as necessary for 'good' patient care so that the supplies and equipment required to provide the service are also funded by government. Therefore, if government approved hospitals are required to provide the services of P.T. and R.T., money for their necessary equipment and supplies would be made available. Specifically, it is vital for paramedicals to have set out in their scope of practice, services which may only be performed by their registered members. These should be specified in the **Hospitals Act** as 'standard ward services'. Traditionally, the medical profession has influenced these decisions through hospital accreditation inspections which are approved by their occupational association.

Government programs such as the Coordinated Home Care Program may also provide employment opportunities for paramedicals. The legal right to own a private practice provides a third alternative site for paramedical work. Within a private practice, the paramedical enjoys the discretion of not only providing services without medical supervision, but of controlling the work domain itself. In both these settings as well, it is important to have the services of an occupation specified as necessary for good patient care so that necessary equipment and supplies surrounding the services may be funded in some way.

Secondly, having determined the types of possible domains, one must then determine the source of funding and its extent within each domain. Evans (1986; 1983), in his comparison of U.S. and Canadian health care funding, continually makes the point that the source of funding is especially important. Is the funding in all domains provided by a single source such as the provincial government? Are different domains funded by different sources? Or is a single domain funded from a multiple source such as government funding, private sources or by individuals? Entire government funding is assumed to be the most reliable and stable. But as the single source of funding, government has the most control in the setting of domain especially if it is administered by one department. The question needs to be asked: Who funds the physical plants, the equipment and supplies associated with each domain? For example; the physical plant, equipment and supplies of the various types of health care institutions may be funded by government. But government does not own, equip or supply private practices. The home care program may receive funding from the government, private insurance and the client. Within this dimension then, occupational control can vary across types of domains and the sources and extent of funding, within each domain.

(b4) income structure

The concept 'income structure' focuses on the services themselves and on the form of payment the provider receives to deliver the services. Since health care occupations are operating within an area that: has ill-defined the type and amount of services required for adequate care, cannot predict the end result of the provision of services with certainty and has not fully established the connection between specific services and predictable results, it greatly aids the control of these occupations if they have their ill-defined and unpredictable services funded by some form of insurance (Larkin 1983, p. 125). It is from the work of Evans (1983, p. 9) that we come to use the term income structure and his insistence that funding includes not only a fee schedule but also a fee structure which focuses on the type of service and providers that are funded. And Evans (1987, p. 633) writes: "All program expenditures are simultaneously, by definition income to someone, usually some class of providers". A formally identifiable health care occupation with a wide range of services stipulated by the terms of its scope with few accompanying gate-keeping restrictions, which are funded within all the domains of work on a fee for service basis, has achieved significant occupational control. The terms of the income structure for the occupations in the health division of labour are found in the hospital acts and regulations, the public health act and regulations and the health insurance act and regulations. The more permanent terms are found within the acts.

First, one should see which occupational services get fully funded by insurance within each domain of work. Then, within each domain of work, one should search for terms that specify the source and the type of income payment for the occupation's services. Within each, one should ask: Are the occupation's services designated as 'basic', 'extended' or 'optional'? This designation would then determine the different funding sources; government insurance, private insurance such as Blue Cross, or by the individual. Which agency determines this? Are the paramedical members paid by salary, commission or fee-for-service? Finally, one should see if physicians get paid for providing similar services within each domain or whether they get funded for providing different ones, thereby reinforcing their respective positions within the health care market. For example: Do physicians get paid by the government for consulting services and paramedicals only for treatment rendered within hospitals, health care programs and private practice? And: Are their type of payments similar within each?

Therefore, an occupation's income structure could vary on types of domain such as the institutions, programs and private practice where the services are provided, on types of income payment such as salaries, commissions or fee-for-service as well as on different sources of funding such as government, private insurance, or the individual depending on the designation of services as basic, extended or optional. These aspects combine into many different control configurations. The configuration representing the most occupational control would be the one having all the occupation's services designated as basic in all domains by the occupation, and funded by government insurance on a fee-for-service basis.

Theoretically, the seven dimensions of Level I could combine to give each occupation a unique configuration of occupational control within the economic marketplace and hence a unique power position or pattern within the health care division of labour vis a vis other occupations. However, control of the various types of agencies within the political marketplace (Level II) is vital. Any formal legislation concerning the control and power relations described in Level I may be initiated and can be amended and approved, by such agencies in Level II. This is what Freidson refers to as the agency structure which he notes:"... creates, alters and sustains the framework of professional activity" (1986, p. 185). This study divides the control of the agency structure into administrative and governing rights. Therefore any changes of control and power within, of, or between the Level II agencies will more than likely affect the occupational control of activities in Level I. The reverse is not true. That is, changes in Level I will not necessarily affect the occupational control of activities found within Level II.

C. LEVEL II: DIMENSIONS OF CONTROL WITHIN THE POLITICAL MARKETPLACE

Gilb's (1966) work is the basis for the development of a general protocol to be used in the search of agency documents including the relevant legislation and government reports. Gilb (1966, p. 137) views the framework of agencies as having different configurations. Some agencies may stand alone, others may have advisory committees to assist them while still others may have boards to whom they must answer, or both. It is from Alford's (1975) insistence that one should examine the member composition of the agencies for the structural embeddedness of members with different interests and from Taylor's (1960) description of the predicted embeddedness of the medical profession within the possible government agencies of health care insurance in Canada, that completes the basis for this protocol. It will be used to search for the membership composition, as well as for the jurisdiction of each agency and for the relationship between agencies.

On each of the dimensions within Level II, the primary agency's title, its membership and its administrative or governing jurisdiction will be sought in the documents along with its administrative or governing interagency relationships. Then, the title and membership composition of the different agencies that oversee or advise the primary agency will be ascertained along with their specified relationships, according to the secondary agency's jurisdiction and rules.

A. Administering Rights

The dimensions within this level range from a jurisdiction over the members of the paramedical occupations via control of their register, to a jurisdiction that encompasses the entire health care system which includes both the members and their supply of services. Generally speaking, occupational control of these rights relate to Freidson's (1970a) concepts of self-regulation and structural autonomy. One would expect to find that paramedicals have some control of the administrative agencies with limited jurisdiction whereas, one would expect the state to retain control of the agencies with a wider administrative mandate. Medicine may have members structurally embedded into important positions throughout the agency structure. The first two dimensions focus on the administration of members through their register but this has been split in two, since the occupation's control and power relations with medicine and/or government may vary with respect to its management and administration. This approach follows Gross's (1984, p. 95) assertion that some activities of autonomous boards are being taken over by central, presumably government, administrative agencies. If the paramedical occupation freely manages and administers its register, it would be self-regulating.

(a1) register management

This dimension which is sometimes referred to as the location of the register, focuses on whether a governmental, medical or paramedical agency or any combination thereof, grants to a paramedical member, the license which entitles him to work in the province. The list of members may be gathered by one agency but utilized by another for the granting of this license such as government's use of a physician held paramedical register (Larkin 1983, p. 157). Therefore, the occupational acts and regulations should be examined to find: the agency's title - often called the Registrar of a professional college or government board - his qualifications, and whether he must be elected, appointed, or hired.

The administrative jurisdiction associated with the

Registrar might include such duties as: the granting of the license, the publishing of the list of active members and the displaying of the list to the public. Its administrative rules might focus on the power relations between administrative agencies and may include such activities as: whether the agency grants these privileges on its own or must submit the name to another agency for approval before granting the license, who funds the agency and to which agencies it must submit any formal reports.

The agencies which may either oversee or advise this agency must be described in their own right. For example, agencies that advise the Registrar may be occupational committees or professional councils whereas, a professional college or government board may oversee the activities of the Registrar. If it is a government agency that oversees the registrar, its membership, jurisdiction and relationship to this agency will be discussed within the dimension entitled "Administrative Responsibility by Government". Occupational agencies which either advise or oversee the Registrar may have their membership elected or appointed by occupational members or by government and may include mandated physicians.

An overseeing occupational body's jurisdiction may include the hiring of the Registrar and his administrative staff and the funding of his activities. An occupational advisory body's jurisdiction may include recommending to the Registrar which members are to be issued licenses. One must also discern how overseeing and advising occupational agencies are financed and to whom they must submit formal reports such as to professional governing councils or government departments? The terms of these duties are found within the occupation's act.

(a2) register administration

Register administration focuses on which agency of government, medicine or the paramedical occupation receives the required information and passes judgement on the eligibility of the individual to be placed, and to remain, on the membership list. That is, it administers the list which may be used by another agency to issue the required license. The occupational credentials and the code of ethics are the basis of this judgement and the terms of this administration process take up a large portion of the occupation's act and regulation. Is the agency entitled as a paramedical, a government or a medical-Registrar, Council or Committee? Is this individual or are the members of this administrative agency elected by their own occupational members, appointed or hired by them or others, based on membership or other specified qualifications? Does its jurisdiction include control of both its members and their private practice in addition to, usual agency duties. Gross (1984, p. 97) identifies many of the administrative duties of this type of agency. The duties include decisions for initial application, renewal application and ongoing registration of the members. Furthermore, they may include assessment of the compliance of members with the competency rules for continuing registration in addition to, investigating, conducting hearings and passing judgement on these members. And they may include prescribing the punishment for member violations of the terms of the code of ethics. This agency will also receive and examine the business credentials of a paramedical's private practice for initial, renewal and continuing adherence to the terms of the business register. These duties must also be described. One must also ascertain whether the agency collects the occupational fees and conversely, if it funds its own activities. A self-financing occupational agency that administers its own register has a great deal of occupational control (McNab 1970).

One must also ascertain if this occupational agency makes these formal decisions regarding the initial, renewal or continuing compliance with the register, on its own. Or whether the registering body or bodies must routinely pass their initial decision to other occupational, medical and/or state agencies prior to their passage. That is, one must see whether advisory bodies assist in making these decisions and pass them on to the main register administering body. And finally, one must see if agencies of the occupation, medicine or government may override or modify these decisions, once they are made. One must also see whether this agency must submit its annual report to another agency.

Then, to reverse the focus and complete the analysis, one must ascertain the ability of other agencies to advise or oversee this agency. As was the case in the dimension "Register Management", paramedical and medical committees and councils may advise this agency whereas, an occupational college or government board may oversee it. Or these occupational bodies may administer the register themselves. Titles of these agencies will be sought. If it is a government board that oversees it, the discussion of that agency will be done within the next dimension, "Administrative Responsibility by Government". An occupational agency that advises or oversees this agency will be examined to see if its membership is elected or appointed solely by occupational members, or appointed by government and whether its membership must be made up entirely of occupational members, or if it is a mixture of mandated government, medical, paramedical or public members.

An agency that oversees this agency may have quite a direct relationship in that it may hire the registrar and administrative staff. Occupational agencies may also hear appeals of the decisions concerning members and businesses. These appeals may be then heard by the courts who will advise the Registrar, or any other administrative agency, of its decisions. Other bodies or agencies may assess either routine or more likely, questionable member applications. It will be important to discover how the activities of the advisory and overseeing agencies are financed and to which other agencies or individuals they must send their formal reports.

Furthermore, within these first two dimensions, different agencies including occupational bodies, may have the important right to prescribe terms (usually bylaws), regarding different aspects of managing and administering their registers. Or they may only initiate these terms (usually regulations) which then must be submitted to another group such as the Medical Association or government administrative agencies. And finally they may be submitted to the Lieutenant Governor in Council who may then pass, modify and pass or reject them. That is, occupations may also have different control in the implementation of new terms.

(a3) administrative responsibility by government

All legislated health care occupations including medicine, have their activities monitored by an overseeing government agency. The key to occupation control is to have this supervision performed by the government agency as indirectly as possible and/or to have members of the occupation structured into important administrative positions of these agencies. For provincial governments who wish to increase their power over the health care occupations, the key would be to administer their activities directly through a specific government agency of occupations whose members are government officials and whose duties are specifically focused on the development of the licensing and the administrating of health care occupations. For medicine, their interest over paramedical activities again is best served by having physicians sitting as mandated members on these governmental overseeing agencies. Which government agency oversees the occupation will be stated in the terms of an occupational act (or its regulations) whereas, the activities of the government agency itself will be found in the formal terms of its act and its regulations. The latter is also described within the agency's annual report.

The difference in the government structure of the agencies that oversee occupational activities will first be identified by title. It may be a government department or a government board operating under a department; for example, the Department of Hospitals and Medical Care or the Health Disciplines Board. Then the agency's possible mandated membership composition must be sought; if these members are elected, hired or appointed and by whom; and if these members are placed within strategic administrative positions within the agency. One must then ascertain the agency's administrative jurisdiction. With regard to the occupation: Does it manage and administer the member register; and does it administer its supply of services?

Then, one must see what other legislation this agency is responsible for, such as any other occupational acts and regulations; or acts and regulations covering other aspects of the health care system such as the funding of the occupation's domain of work. Is the other legislation restricted to the health system? Administrative rules may include: the mandated use of advisory boards and the mandated reporting of its activities to another government overseeing agency such as the legislative assembly. Related to this, one must see how its activities are financed.

Conversely then, one must focus on the agencies that advise and oversee the government agency in question, either directly or indirectly. For instance, an advisory agency entitled a committee or council, may directly advise this agency and the Minister of the Executive Council responsible for that agency may directly oversee its activities. Alternatively, the Minister through another type of advisory agency may indirectly advise Executive Council (Provincial Cabinet) and/or may indirectly oversee this government agency. Much of this structural difference is found in the titles of the various agencies; for example, the Health Disciplines Board and the Minister of Professions and Occupations. Again, the mandated membership composition of the agencies must be ascertained for members of government, medicine and the paramedical members. Then we must inquire whether these members are hired, elected or appointed and by whom.

Furthermore, the relationship of these various agencies to the initial government overseeing agency must be ascertained through their legislative jurisdictional responsibilities and administrative rules. For instance: Does one of these agencies initiate and pass acts and regulations which the initial agency must follow? Or does the initial agency, perhaps on the advice of one of its advisory councils, initiate legislation which another agency passes, amends and passes or rejects? In this case, the final overseeing legislative agency is the Cabinet and the implementing rule is the Lieutenant Governor in Council. Further mandated administrative rules of these agencies that oversee or advise this government agency must be found. For instance: Must this agency hold public meetings for input on their decisions? Must they submit their proposed actions first to interested occupational groups before passage, or to the Cabinet or the Legislative Assembly for passage? How are these various agencies financed?

Government administrative agencies usually must publish an official annual report and from its self-description, one can find its self-defined activities. This is especially important when the terms of the agency's legislation are only vaguely defined.

(a4) administrative co-ordination by government

This dimension could be subtitled: An Organizational Chart of Government Administrative Agencies as They Relate to Paramedical Occupations. The usual supposition is that each profession will be self-regulating and have its own administrative board, with no co-ordination existing between occupational boards (Gross 1984, p. 107). Gilb (1966, p. 151-52) extends this assumption to say that an agency of government may oversee the occupation's activities but again would predict that a single agency that administers one occupation and relies on that occupation for its information, would allow that occupation effective control of it . But Gilb (1966, p. 184) also maintains that an agency which oversees many different types of activities has a wider interest than the occupation and therefore, may not act so readily in the occupation's self-perceived interest.

These patterns of coordination would be that of insular self-administering member occupations with no formal coordination among them or of single government administered, occupationally controlled, member agencies with no formal coordination among them. There may also exist a pattern in which a government administration agency may administer a number of different occupational activities including their funding. It would be predicted that this agency would not be as controlled by a single occupation due to the wider jurisdiction of interests or vision. However, as has already been described, even this wider jurisdiction may be controlled by occupational members holding strategic administrative positions. Furthermore, with the addition of new types of government administrative agencies, there may also be a combination of a number of government agencies administering one occupation's activities including its members, and different aspects of its supply of services including its funding. Or, there may a number of agencies administering this same jurisdiction either directly or indirectly. Generally speaking, all government administrative agencies related to health are predicted to have physicians situated in important positions. The task here would be to seek the pattern of coordination of these physician infiltrated, government administrative agencies given their different jurisdictions, as they impinge on P.T. and R.T. activities either directly or indirectly. And finally, we must observe at what level, full administration coordination is fully realized.

Therefore, in searching the documents for information related to this government administrative framework, we will look at the possibility that a government administrative agency such as a Health Disciplines Board may directly administer the occupational legislation of all, or many, aspects of many paramedical occupations, while another government agency such as the Department of Hospitals and Medical Care, may both directly and indirectly administer many of the one occupation's activities as it relates to both the members and their supply of services. Or many agencies such as the Health Disciplines Board, the Department of Hospitals and Medical Care and the Department of Community and Occupational Health may directly administer different activities of one occupation. Presumably, one government administrative agency, or a combination of cooperative government agencies, which had physicians structured into important positions within them, and which directly administered legislation encompassing all the occupation's activities, would leave the occupation little control.

One must also search for any formal administrative rules these agencies must follow in communicating with each other such as by shared minutes and formal notices of meetings. One can then see if any agency is not directly part of this interconnection. The assumption here is that all these government agencies are funded by the government. And finally, one should describe the agency level in the government administrative apparatus at which the total administrative co-ordination of health occupational agencies is achieved. For instance, this co-ordination will at the very most, always be accomplished at the Cabinet level of government and through the Lieutenant Governor in Council. That is, the Cabinet can pass regulations encompassing the entire health system if these rights are found in the enabling terms of the various acts passed by the legislature.

(a5) administrative change by government

Governments in Canada may establish a formal inquiry known as a Royal Commission, related to any specified topic, if they wish to initiate, to direct or perhaps, to co-opt even broader change within the health system. The Alberta government has initiated Royal Commissions to study the licensing of occupations (The Chichak Commission) and the future of health care in Alberta (The Hyndman Commission). These commissions issue detailed permanent final reports. It is Alford's (1975, p. 22-24) specific methodology that allows for the examination of these documents and a truncated version of his methodology will be followed here. First, the agency's (in this case the Royal Commission's) title should be stated, the membership of the commissioners should be examined for identifiable characteristics of occupation or other social characteristics, in addition to whether they were elected, appointed or hired, and by whom. The jurisdiction and rules for implementing the study should be ascertained, in addition to who called and funded the commission, who may cancel it, and finally, who is asked to give input.

It is Alford's (1975) contention that the makeup of a commission by members with different group interests are manifest in the final recommendations of the commission which often result in no recommendation for deep structural change but are instead either vaguely worded or propose superficial change. Alford (1975, p. 25) calls this dynamics without change. The co-opting of real change then, can be discerned within the final report by examining its title and the recommendations proposed. The actual recommendations should be examined to see if some important changes are actually specified or whether they are just fuzzy rhetorical statements.

The assumption within this study is that government commissions are government funded. Government agencies such as the Premier, the Cabinet and the Legislative Assembly may be able to call and cancel the commission and other interested agencies such as medicine, paramedicals and the public, may be called on to advise the commission and to submit briefs. Alford's (1975, p. xii) position is that due to structurally embedded interests, certain identifiable groups such as medicine, will not have to defend their interests very strongly, while other interested groups such as the public, (and conceivably the paramedicals) will have their concerns co-opted in the review process. The examination of a royal commission utilizing this methodology will help us to understand whether state and medical interests are primarily antagonistic, mutually reinforcing or simply separate which could result in recommendations for possible important structural change.

B. Governing Rights

This section specifies the agencies that freely govern and can freely define, (or have a monopoly) within some jurisdiction of the paramedical membership, the supply of their services and their related administrative agencies. Agencies with governing capabilities may affect some aspect of paramedical activities either directly by occupational by-law or indirectly by Ministerial orders, the Lieutenant Governor in Council and of course, the Legislature. Since the modern state (especially the modern welfare state) is so complex, the legislature delegates its powers to other sectors of the government through enabling terms of legislative acts. The governing jurisdiction which these agencies hold are stipulated within the enabling legislation (Cowan 1988, p. 15). That is, the right to pass by-laws, ministerial orders and orders in council are granted through enabling terms within the acts.

(b1) indirectly: by the legislature

The title of this governing body is the provincial Legislative Assembly and its members, who are usually representatives of political parties, are elected by the public. Historically, some influential members have been physicians, so members of that profession should be located if possible, as well as members of the paramedical occupations in question. The historical governing jurisdiction of the provincial legislative assembly primarily focuses on schools, health and social services, highways and municipalities (Ruff 1988, p. 1174). For paramedical occupations, it is the role of the province in the growth of health services that is of particular relevance. This agency has the governing power to set the terms under which the Lieutenant Governor in Council, Ministerial Orders and Occupational By-laws may operate.

Therefore, while the governing rights of the other bodies are granted within the terms of various Acts, it is the Legislative Assembly by way of the Legislature, that passes the acts themselves. This is the governing agency with the final authority to define the rights of the occupational members, the supply of their services and the duties of other agencies within the political marketplace which both administer and govern their activities. For paramedical occupations, this body has the ultimate, albeit the most indirect, power over their activities.

The formal rules under which this agency operates allow it to initiate and pass legislative acts. In theory this agency is supposed to embody a democratic process by elected members. In fact, party loyalty and party government control of the Legislative Assembly is held by the Premier and his Cabinet. "With the modern emphasis on executive government, the lawmaking powers of the Cabinet and its individual ministers is considerable" (Ruff 1988, p. 1776). Therefore, while the Legislature may encompass the widest jurisdiction and hence have the widest vision, it does not effectively govern within its jurisdiction: the Cabinet does.

(b1) indirectly: by the lieutenant governor in council

The Lieutenant Governor in Council is often given the right to pass, amend and pass, or revoke the proposed regulations of other governing bodies; and to initiate and to pass its own regulations which are called 'orders in council' (Forsey 1988, p. 1584). The agency which may initiate and/or approve these regulations is the provincial Cabinet. These proposed regulations are then routinely signed into law by the provincial representative of the Crown, the Lieutenant Governor if they are to become part of administrative law. Hence, the term the Lieutenant Governor in Council is used to denote this implementing process. That is, Cabinet may initiate and pass regulations concerning paramedical members, their supply of services and their administrating agencies if that right is specified within the enabling terms of the act related to their occupational activities. This jurisdiction over which Cabinet may govern will be described in the analysis as found in relevant legislation. This process is similar to how Ministerial Orders are defined.

The membership of Cabinet includes the ministers responsible for some provincial jurisdiction. It is headed by the Premier. Its composition should be examined to see if any physicians, R.T.s or P.T.s, are identified as members. The combined jurisdiction of this group encompasses all provincial responsibilities of which, health care occupations are just a fraction. Their vision as a combined group is therefore very widespread and on the basis of Gilb's (1966) prediction, would not be swayed as readily by occupational interests, as would the more limited administrative agencies. However, as was described earlier, the dynamics for paramedicals may differ in that the government administrative agencies may be embedded with physicians in key administrative positions and therefore the governing agencies such as the Cabinet may be more receptive to their interests.

(b1) indirectly: by ministerial order

Ministerial orders are executed solely by a provincial minister under rights given to him by terms of the various Acts. Again, it is from the enabling terms within these acts that these governing individuals, not agencies in this case, are given governing rights. They are usually more specific than the rights given to the Lieutenant-Governor-in-Council and may range from the right to determine funding stipulations within classes of eligible groups, to passing orders within the areas of departmental administrative jurisdiction for which they are responsible. The governing rules are usually stated in such a way that the minister alone may stipulate 'orders' and thus, they are labelled

Ministerial Orders. The terms within ministerial orders often state how violations may be sanctioned (such as by having funding cut) and whether a ministerial decision may be appealed to other agencies. Since they do not need to be passed by the Lieutenant-Governor-in-Council, they do not become part of administrative law.

The title of the Minister should be ascertained to see if he is responsible to the Cabinet for a relevant act, bureau, board or department or any combination of these jurisdictions since Ministers usually have "assignments for policy areas" (Ruff 1988, p. 1774). This governing right relates to the jurisdictions within which he may solely initiate and pass ministerial orders, with a focus in this study, on the occupational members, their supply of services and the government admission agency.

(b2) directly: by occupational by-law

The most important means of obtaining direct occupational governing rights is by occupational by-law since by-laws may be initiated and passed solely by agencies composed of their own members. By-laws are not in most cases, part of administrative law and they are not directly sanctioned by the courts. Rather, sanctions are applied by the occupation's own bodies.

These stipulations become binding on the members of the occupation by virtue of other rights granted to the occupation. They will be especially effective in controlling member compliance if it is stated within the terms of the occupational Act that any violations of the by-laws will be charged as professional misconduct and sanctioned in the extreme, by a cancellation of that member's registration. Furthermore, if the suspension of membership prohibits one from engaging in essential activities such as the ability to work, this pattern becomes a powerful legal weapon to attract and control members and the supply of services. Traditionally, the prime example of this pattern of power is that of the medical profession. This interlocking pattern illustrates why the occupation must try to control all the dimensions in the framework. The quest for this pattern of absolute occupational control then is to have the jurisdiction over which the occupation may pass by-laws extended as far as possible and to have effective sanctioning authority.

The title of a body having the right to pass by-laws will be sought. It may be called a college, council, committee or association. Its member composition will be ascertained and whether any other members have mandated representation, will be noted. The occupational acts will be examined for terms of enabling legislation that grant it the right to initiate and pass by-laws, in the first place. Then, its governing jurisdiction will be sought. This jurisdiction may apply to its own members, their supply of services and any administration agencies. And how violation are sanctioned will be described. The governing rules in this case, will be by occupational by-law. The agency able to pass the by-laws is likely to be self-financing rather than dependent on government funding.

CHAPTER VI: ANALYTIC DESCRIPTION OF LEVEL I: DIMENSIONS OF CONTROL WITHIN THE ECONOMIC MARKETPLACE

A. INTRODUCTION

In the preceding chapter the framework of occupational control was presented. Its presentation there was of a general nature which emphasized its directive approach. In this respect, it is claimed that the framework has general applicability and may be used with appropriate modifications, to study the legislation and other formal documents pertaining to occupations in health care. The analytic description in this chapter follows the dimensions and detail discussed in Chapter V but is now based on the terms found within the various types of documents.

The framework was developed specifically to explore and analyze the documents of Physical Therapy and Respiratory Therapy. The objective of this research is to describe the legal privileges and restrictions of these two paramedical occupations in order to determine if paramedical occupations such as these two, have any control and if so, to outline the form it takes. Chapters VI and VII present the analytic description which resulted from this research. The organization of this description follows the order of the framework found in Figure 5 of Chapter V. Because of the length of the analytic description, it is divided into two parts. In this chapter, only the description relating to occupational control within the economic marketplace (Level I), is presented. The description of Level II is presented separately in Chapter VII.

B. ENTITLEMENT CONDITIONS OF/FOR OCCUPATIONAL MEMBERSHIP

(a1) right to title

Traditionally, the importance of the title is due to fact that it is used as a signal to the prospective patient that this member has met certain standards. In the current situation it is also a signal for further governmental legislative rights. A new title "physical therapist" and the abbreviation P.T., can only be used by a therapist registered under the more recent terms of the **Physical Therapy Profession Act** [PTA: s20(1)(a) & (b)].[1] Title restrictions also apply to the more specified practices of "registered practitioners" and "physical therapy corporations" which are listed on separate registers under this Act [PTA: s3(1)]. A registered practitioner is a member who may only practice physical therapy in a limited manner [PTA: s1(o)]. A physical therapy corporation may only practice under its corporate name or another name approved by the Physical Therapy Council [PTA: s22(1)]. The courts may grant injunctions against individuals violating the use of any of these names, titles or abbreviations [PTA: s7].

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[1] For Legislation Title Abbreviations: see the listing at the beginning of the thesis.

However, health care practitioners practising under another Act are exempt from the control and restrictions found in the terms of this Act [PTA: s4(2)]. And as noted in Chapter III, prior to the passage of the **Physical Therapy Profession Act** practitioners were entitled "certified physiotherapists". The new act did not secure control of the old title "physiotherapists" when they were granted the new title "physical therapists". In 1988 therefore, physiotherapists who lacked the credentials to be registered under the new title were free to continue practising but were not entitled to further government privileges or restrictions.

In 1988, Respiratory Therapy was changing its title from Respiratory Technology to Respiratory Therapy [RTR:Alberta Regulation 508/87] and its members may use either the title Registered Respiratory Technologist or Registered Respiratory Therapist and the abbreviation R.R.T. [RTR: s9]. As with Physical Therapists, only the specifically qualified members listed on their register are permitted to use either of these titles [HDA: s2(1)(a)]. And, as was seen in the **Physical Therapy Profession Act**, nothing in the **Health Disciplines Act** applies to practitioners entitled to practice under any other Act [HDA: s2(4)]. In the case of this paramedical, as with others legislated under the **Health Disciplines Act**, it is the Health Disciplines Board that initiates regulations concerning the occupational title and abbreviations. [HDA: s27(m)].

(a2) occupational credentials

R.T. members are formally legislated under both the general terms of the **Health Disciplines Act** and under the more specific terms of the **Registered Respiratory Therapy Regulations** and are therefore subject to the terms within both. In every instance, the member must submit an application for registration or renewal. However, in 1988 under a committee/board relationship, fees were paid to the Provincial Treasurer not to the paramedical association [RTR: s2(e)]. And the Health Disciplines Board may initiate by regulation, registers of temporary licenses [HDA: s27(1)(0)] and specify their limitations and restrictions [HDA: s27(1)(p)], in addition to setting the fees of registration, renewal and for conducting exams [HDA: s27(1)(n)].

Under Subsection 12(1) of the **Health Disciplines Act**, a person generally is eligible for registration when: he meets the qualifications spelled out in the regulations, is of good character and reputation and has paid the fees prescribed in the regulations [HDA: s12(1)(a),(b)&(c)]. More specifically, Section 2 of the **Registered Respiratory Therapy Regulations** declares that a person is eligible for registration when he has completed an "approved" program of studies and has passed an "approved" examination [RTR: s2 (a)&(b)]. He must also declare that in the 18 months prior to his application, he has been employed 240 hours as an R.R.T. or has completed an "approved" refresher course [RTR: s2(c)(ii)&(iii)]. The "approved" program, exam and refresher course are all designated as such, by the Health Disciplines Board [RTR: s2(a)(i),(b),(c)(iii)]. There are no formal registers established for temporary R.T. licenses.

To annually renew his registration, the R.T. member must have completed the prescribed program of studies and within the preceding year, must have practised for 160 working hours or must have followed the R.T. Committee's recertification requirements [RTR: s3(1)(a),(b)&(c)]. The training programs, examinations and refresher courses that the R.T. Committee may prescribe must also be approved by the Health Disciplines Board [RTR: s3(4)(a),(b),(c)].

For P.T.s, terms within their own Act, Regulations and By-laws specify the requirements needed by both members and businesses to be placed on their respective registers. As with R.T.s, they must also meet the general member requirements of possessing certain individual characteristics and educational credentials and of paying fees [PTR: s5]. The registration fees of members and corporations are set by the P.T. Council in its by-laws [PTA: s74(1)(n)]. There are in fact, three types of registers: those of "physical therapy", "physical therapy corporations" and "registered practitioner"

[PTA:s(1)(a)(b)&(c)]. The registered practitioner registers include: an Educational Register, a Special Clinical Practice Register and a Courtesy Practitioner Register [PTR: s7(1)(a)(b) & (c)].

The member credentials needed to be placed on the main physical therapy register include: an undergraduate degree in physical therapy from an approved program [PTA: s17(1)(a)(i)] or its approved equivalent [PTA: s17(1)(a)(ii)], the stipulated character requirements [PTA: s17(1)(b)] and the fees prescribed in the Physical Therapy By-laws [PTA: s18(1)(b)]. The P.T. Council may initiate regulations for the determination of the character credentials of applicants [PTA: s73(1)(b)] and stipulate by-laws concerning the fees payable to the P.T. College for registration [PTA: s74(1)(n)].

The approved academic program of Physical Therapy in Alberta is accredited by the University Coordinating Council [PTA: s11(1)]. This University Council also nominally inspects the qualifications of individual applicants from other programs for register requirement equivalency [PTA: s17(1)(a)(ii)]. However, the University Coordinating Council may delegate much of its control to a special committee appointed by the University Council [UA: s64(3)(a) & s 64(3)(b)]. This committee will be composed of the occupation's active members [UA: s64(2)(a)], its active educators [UA: s64(2)(b), other members the University

Council wishes to appoint after consulting with the governing body of the occupation [UA: s64(2)(c)] and at least one public member [UA: s64(2)(d)]. The Physical Therapy Council on the other hand, has the direct right to initiate regulations of clinical credentials [PTA: s73(1)(c)].

Furthermore, the Physical Therapy Council must establish a Practice Review Board which reports to the Council on the practice of physical therapy generally [PTA: s33(a)(iv)] or more specifically, on the proposed standards of competence of physical therapy and registered practitioner members [PTA: s33(a)(ii)]. It is composed of at least five members, four of whom are physical therapists appointed by the Council [PTA: s32(1)(a)] and one public member appointed by the Minister from a list of names submitted by the Council [PTA: s32(1)(b)]. The P.T. Council has the right to initiate regulations establishing different registers for various categories of registered practitioners [PTA: s73(1)(p)] and stipulating related restrictions on their practice [PTA: s73(1)(o)]. Registered practitioners listed on these different registers are granted only temporary licenses [PTR: s8(2),s 9(2)& s(10(2)] which are usually cancelled when the need for that type of registration is finished [PTR: s9(3)& s 10(3)].

Consequently, as found within the **Physical Therapy Regulations**, a registered practitioner listed on the

Educational Register is generally an applicant lacking practical experience [PTR: s8(2)(a),s 8(2)(b)&s 8(2)(c)] or in the process of upgrading academic deficiencies [PTR: s8(2)(d)]. Individuals placed on this register for lack of practical experience [PTR: s8(2)(a)(b)&(c)] may only practice in an accredited facility under the supervision of a physical therapist [PTR: s7(2)]; individuals with academic deficiencies [PTR: s8(2)(d)] may practice freely [PTR: s7(2.1)] for a limited time [PTR: s7(3)].

A registered practitioner is listed on the Special Clinical Practice Register when his initial application or his renewal application for registration is refused by the Registration Committee of the Physical Therapy Council [PTR: s9(1)]. He must obtain the specific further experience required by this Committee to make up this deficiency [PTR: s9(3)] and while listed on this register, he may only practice in an accredited facility under a physical therapist [PTR: s7(2)]. A registered practitioner listed on the Courtesy Practitioner Register is someone who is entitled to practice outside Alberta but wishes to practice temporarily in Alberta for one of several valid reasons [PTR: s10(1)]. Since he holds the necessary academic and practice requirements, he may practice in Alberta without supervision [PTR: s7(2.1)].

The requirements for the annual renewal of member registration include the usual fees [PTR: s5(2)(a)] and evidence that the individual has graduated from an approved program within the last three years [PTR: s6(1)(a)] or has, within the past five years, practised not less than 1550 hours [PTR: s6(1)(b)] or has averaged 310 hours of practice per year in the time period from January 31, 1985 to January 31, 1990 [PTR: s6(2)]. These requirements then, require continuing competency, fitness and active clinical practice [PTR: s6(3)] and the usual fee. These regulations are reinforced by section 19 of the **Physical Therapy Act** which stipulates that a renewal applicant must meet the requirements set down in the regulations [PTA: s19(2)(b)] and pay the annual fee [PTA: s19(2)(c)].

The Physical Therapy member dominated, Practice Review Board has the right to generally assess and develop the educational and clinical credentials for renewal [PTA: s33(a)(i)]. But the P.T. Council itself, can initiate regulations to determine the credentials for the annual renewal of registration [PTA: s73(1)(q)] and the requirements for compulsory continuing education [PTA: s73(1)(j)]. The Council can establish by by-law, the membership fees payable to the P.T.College [PTA: s74(1)(n)].

Terms within the **Physical Therapy Act** itself, state that the P.T. Council may also establish a Register of Physical Therapy Corporations names [PTA: s21]. Furthermore, this Council may establish by-laws specifying further requirements that must be met for the registration of practices [PTA: s74(w)]. The general requirements for registration of corporations are: submission of the Council prescribed fees [PTA: s23(1)(b)], Registrar acceptance that the practice is a corporation in good standing with the Registrar of Companies under **The Companies Act** or the Registrar of Corporations under **The Business Corporations Act** [PTA: s23(c)] and finally, that only physical therapists are practising within it [PTA: s23(g)]. Specifically, if that corporate ownership is in the form of a partnership, the practice must be at least 75% owned by registered physical therapy members [PTR: s20(b)] and if by shares, it must be 75% owned by members [PTR: s20(c)(i)(A)] and physical therapy members must have 75% of the voting rights [PTR: s20(c)(i)(B)]. More specific practice occupational credentials include: having corporation by-laws and incorporating documents that allow the practice to fulfil the conditions found within the P.T. By-laws [PTA: s23(1)(d), having a name that fulfils by-law stipulations [PTA: s23(1)(e)] and having its legal and beneficial ownership of shares and its officials elected or appointed in accordance with the by-laws [PTA: s23(1)(f)].

That is, the terms of both this Act and the accompanying Regulations apply to the physical therapist performing services to a patient in private practice [PTA: s72(1)] and the terms within the by-laws specify requirements to be met by the practice itself [PTA: s23]. If any of these requirements are violated, the corporation practice permit will be withheld, suspended or cancelled by the P.T.Council [PTA: s23(3)]. Furthermore, if a physical therapy member connected with a private practice violates any of the terms of the Act, he is given stiff penalties on conviction of the offense [PTA: s76(1)(a)] and subsequent offenses [PTA: s76(1)(c)].

(a3) code of ethics

These specified terms will typically include a statement of concern for the patient's interest, a general statement reinforcing adherence to the legal terms of the Act, Regulations and By-laws and more specific statements about member competency and conduct, inter-occupational and intra-occupational competition.

In the case of Respiratory Therapy and as found within the dimension "occupational credentials", it is the Health Disciplines Board which may initiate the standards of conduct and competency of the registered R.T. member [HDA: s27(1)(f)] following possible recommendation of an Ministerial appointed Advisory Committee [HDA: s4.01]. The provision that R.T. services are to be performed in the patient's best interest is found in the **Respiratory Therapy Regulations.** Subsection 8(c) of the regulations states that: "A registered member shall execute his duties in a competent manner being guided at all times by the welfare and best interest of the patient." And while there is no term that specifies that R.T. members must follow every term of its act, regulation and bylaws, subsection 8(e) of the regulations states that they must report any conduct of a paramedical practitioner that is "illegal" as well as "incompetent" or "unethical".

Most ethical statements refer to the competency and conduct of the member. For instance with regard to R.T. competency, the registered member must:".. maintain currency of practice of respiratory therapy and upgrade his knowledge and skills with the development of new procedures and equipment" [RTR: s8(f)]. This particular ethical statement reinforces the educational terms of credentials deemed as necessary to be placed on the register, and to continue to be registered.

Ethical statements may also reinforce the structure of competition between the various occupations, the terms of which will refer to the delivery of services to be included ethically in the scope of practice and the gate-keeping restrictions. For instance, the R.T. registered member is obligated to "work in co-operation with his colleagues and other health care personnel" [RTR: s8(g)] and must work "within his scope of practice and capability" [RTR: s8(b)]. And the member must only provide services listed in the regulations [HDA: s2(2)(a)] along with the stated restrictions [HDA: s2(2)(b)].

Ethical statements may also reinforce the occupation's competition rules between members of the same occupation; these relate mostly to private practice. Traditionally, this has taken the form of prescribed restriction on the type of advertising allowed. Within the **Respiratory Therapy Regulations**, there is just a vague statement relating to the R.T. ethically prescribed domain of work in that R.T. members must work within "any applicable limitations and conditions placed on the provision of health services" [RTR: s8(b)].

The Council of the College of Physical Therapists has been given the right within the **Physical Therapy Act** to initiate regulations concerning various aspects of its code of ethics. Subsection 73(1) grants the Council the right to initiate regulations on a code of ethic, the standards of practice and the rules of permitted advertising [PTA: s73(1)(a)(d)(l)]. The specific terms of the physical therapy code are therefore found in the **Physical Therapy General Regulations**.

The statement of concern for patients in the **Physical Therapy Regulations** is rather unique: "A physical therapist, registered practitioner or physical therapy corporation shall serve a patient in a conscientious and diligent manner and shall provide a quality of service equal to that which a competent physical therapist would generally expect..." [PTR: s11(1)(b)].

General statements reinforcing a physical therapist's conduct and competency say that a physical therapist, registered practitioner or physical therapy corporation must be competent [PTR: s11(1)(a)] and must not conduct themselves in a manner that implies lack of knowledge or lack of skill or judgement [PTR: s11(2)(c)]. Specifically, a member must not violate; the public interest [PTA: s37(1)(a)], the Act and Regulations [PTA: s37(1)(b)], the "profession of physical therapy" [PTA: s37(1)(c)] and knowledge, skill or judgement in practice [PTA: s37(1)(d)]. And once being investigated, the member must not violate any of the terms of the Act, Regulations or By-laws, or he will be further charged with "professional misconduct" [PTA: s37(2)]. These statements then reinforce the terms of the physical therapy credentials.

Other terms reinforce the status of inter-occupation competition in that no physical therapist, registered practitioner or physical therapy corporation will treat a patient unless he has been referred by a doctor, dentist or dental surgeon [PTR: s21(1)]. This statement reinforces the type of gate-keeping rights that physicians hold over physical therapy services. On the other hand, no physical therapist, registered practitioner or physical therapy corporation may teach physical therapy to an individual outside of an approved physical therapy program [PTR: s17]. Furthermore, no physical therapist may provide services in private practices other than those listed in the Physical

Therapy corporate register [PTR: s20(a)].

Interestingly, most of the physical therapy code of ethic regulations relate to intra-occupational competition with an emphasis on advertising prohibitions. Generally speaking, a physical therapist, registered practitioner or physical therapy corporation must advertise his practice and attract patients in accordance with these specified rules [PTR: s12(1)]. More directly, a physical therapist, registered practitioner or physical therapy corporation may not treat a patient who:"... is undergoing treatment by another physical therapist, registered practitioner or physical therapy corporation..." except in the specific cases listed [PTR: s14].

C. ENTITLEMENT RIGHTS OF SUPPLY OF OCCUPATIONAL SERVICES

(b1) scope of practice

The R.T.'s scope of practice is very deliberately specified within their regulations. They may, among other things, perform patient evaluation, administer aerosol and humidity therapy, do blood gas analysis, non-invasive cardiopulmonary testing and monitoring, and give capillary punctures [RTR: s6(1)]. They may even assist in giving anaesthesia [RTR: s7(3)(d)]. In addition, R.T. members may be involved in: the maintenance of the equipment used in these types of health services, in research and education involving these services, in the administration and supervision of programs involving these health services and in the management plan of respiratory therapy itself [RTR: s6(1)(p)]. While the Committee of R.T. members set up by the Minister may give advice on these matters [HDA: s6(c)], it is the Health Disciplines Board that initiates the regulations regarding the services that the R.T. members may provide [HDA: s27(1)(a)] which the Minister appointed Advisory Committee may possibly recommend to it [HDA: s4.01].

The scope of practice of physical therapy is more definitional and vague, yet much broader. It includes: "... the application of professional physical therapy knowledge, the assessment and treatment of the human body in order to obtain, regain and maintain optimal function by use of any suitable medium of therapeutic exercise, message and manipulation or by radiant, mechanical or electrical energy..." [PTA: s1(k)]. In this instance, it is the Physical Therapy Council, not a government Board, nor a government Advisory Committee, that may initiate regulations concerning the "restrictions, conditions or limitations" of practice [PTA: s73(1)(e)] which may include terms of its scope of practice.

(b2) gatekeeping rights

R.T. Regulations include differing stipulations related to gate-keeping. The most lenient stipulation is that of working "under the supervision of a physician" [RTR: s6(3)] which is defined as: "by written order or instruction by a physician" [RTR: s1(g)]. The next provision, a modestly stringent one, states that specified services done by a specified member, must first be given the consent of the hospital board and must be performed under the supervision of a physician [RTR: s7(1)]. The most restrictive requirement is that some services require the consent of a hospital board, in addition to "direct supervision" [RTR: s7(3)]. This restriction entails "continuous and visual observation" by a physician who is present while the service is being provided [RTR: s1(c)]. These stipulations are reinforced by the terms of Subsection 2(2)(b) of the **Health Disciplines Act** which states that a registered person must perform only those services prescribed in that discipline's regulations, subject to the prescribed restrictions.

Again, while the Committee of R.T. may advise the Health Disciplines Board on the limits and conditions attached to their services [HDA: s6(c)], it is the Board that generally has the power to initiate the regulations that govern the gate-keeping conditions [HDA: s27(1)(b)], subject to possible Advisory Committee recommendations [HDA: s4.01].

Physical Therapists also have their services gatekept but in a much different form. All physical therapists must provide their services within the medically controlled care system in that they have access to patients "by referral only" from a physician, dentist or dental surgeon [PTR: s21(1)]. However, as seen within their scope, these services include both "treatment and assessment" [PTA: s1(k)]. These stipulations allow them to control many of medicine's traditional gate-keeping rights such as prescribing, treating and evaluating the patient's condition, once the referral is made. And it is the Council of the Physical Therapy Association, not medicine or a government agency, which may initiate regulations prescribing the various restrictions, conditions or limitations on the practice of Physical Therapy [PTA: s73(1)(e)].

However, given these gate-keeping restrictions, the members of the two paramedical occupations studied have the right to perform their services within the wide spectrum of medically defined diseases, medically initiated diagnosis and medically approved types of treatment. This is specifically written into the P.T.'s Act in which their services are limited, or expanded, to include assessment and treatment within the limits of Section 77 of the Medical Profession Act [PTA: s1(k)]. Section 77 of that Act holds that medicine's scope includes the: "...willingness or ability... to diagnose or treat any disease, illness, deformity, defect or injury" [MPA: s77(1)(a)] and "the prevention, alleviation and cure of any ailment, deformity, defect or injury" [MPA: s77(1)(c)].

(b3) domain of work

Unfortunately, for paramedicals such as R.T., who are legislated under the **Health Disciplines Act**, their right to title, defined scope of services and prescribed gate-keeping requirements do not ensure their members the exclusive right to perform their occupational services within Alberta government approved hospitals. Subsection 2(3)(a) of the **Health Disciplines Act** stipulates that this Act does not "affect or constrict" the operators of approved hospitals, nursing homes, or the institutions and programs approved by the Minister of Community and Occupational Health, from "prescribing" the duties of his employees. Furthermore, another subsection [HDA: 2(3)(b)] states that any employee must be allowed to perform the services set out in institutionally prescribed duties. The R.T. member could conceivably perform all the duties set out in his scope [HDA: s2(2)(a)] subject to the prescribed gate-keeping restrictions, but only if permitted to do so by the operator of that institution [HDA: s2(2)(b)].

The "duties of employers" are set down more clearly in the P.T.'s act in that: no one is to be hired to provide physical therapy services unless that person is registered under that Act [PTA: s6(1)], no employer can require someone else to perform physical therapy services [PTA: s6(2)] and the courts may grant an injunction forbidding these practices [PTA: s7]. Furthermore, the P.T. Council may initiate bylaws which grant them the right to designate which facilities are to be accredited [PTA: s74(1)(x)] and therefore, acceptable work institutions for their members.

And from the institutional acts and many regulations, it is stated within the **Operation of Approved Hospitals Regulation** that when medical association accrediting inspections are carried out within Alberta, the hospitals must only "strive" to meet any recommendations of the medical accreditation committee [s 33(i)]. However, if the hospitals plan any major change in introducing, changing or terminating existing services, it is the Minister of the Department of Hospitals and Medical Care that must approve the proposed change [HAR: s27]. Physicians on a hospital's medical staff do retain the ex~~clusiv~~e right to admit patients to governmentally approved hospitals [HAR: s10(1)].

Furthermore, as stated in the **Hospitals Act**, the medical staff within each hospital who are physicians appointed by a hospital board [HA: s26(d)], are responsible to that board for clinical and scientific work performed; and they advise the board on all matters of patient care [HA: s29(a)]. These physicians are also responsible to the board: for reviewing medical staff professional practice as well as that of other members of the hospital treatment team [HA: s29(b)], for the improvement of patient care [HA: s29(c)] and for making recommendations concerning the utilization of the hospital itself [HA: s29(d)]. However, each approved hospital within Alberta has a governing board that has full control and "absolute and final authority on all matters pertaining to the operation of the hospital" [HA: s27]. This board appoints an administrator who is responsible to the board for the day to day operation of the hospital [HA: s26(a)]. This board also enacts the by-laws within each hospital which may govern the duties and responsibilities of the hospital staff [HA: s28(3)]. And it must produce detailed bylaws of the organization and administration of hospital departments or on any other matter considered to be important by that board [HA: s28(3)]. A copy of these by-laws must be sent to the Minister [HA: s28(2)].

Another legally constituted group, the Alberta Hospital Association functioning under the terms of its own act, performs liaison functions: between the members of the association itself [AHA: s5(c)], between themselves and employees of their institutions [AHA: s5(e)] and between themselves and other related groups such as the government and its various agencies [AHA: s5(d)]. The Board of Directors of this association [Alberta Hospital Association] are elected or appointed according to the association's own bylaws [AHA: s7(1)]. Matters discussed by the members focus on hospital and other "health care services" which include such items as "drugs, medications, supplies and appliances related to health care" [AHA: s1(c)], "planning, constructing and equipping" of hospitals and other facilities that provide these services [AHA: s5(c)(i)], as well as the organization, management and administration of the services themselves [AHA: s5(c)(ii)], among other things.

However, with regard to Alberta hospitals, a government Minister after establishing a district [HA: s2(2)] where a hospital is to be erected, will call for specifications within a hospital program which will include an estimate of its capital construction [HA: s5(1)(b)], among other things. This extra cost cannot be passed onto the population within the municipality [HA:8(3)]. And, all approved hospitals in Alberta have the "purchase, replacement and installation" of equipment funded by the Alberta government, subject to restrictions placed by the Minister [HBR: s25(2)]. This government funding could conceivably cover the goods and equipment required to deliver paramedical services. Furthermore, the provincial government of Alberta funds the operating expenses of the inpatient goods and services which are provided within a government approved general hospital program or a more specific hospital program [HBR: s7(1)(a)(vi)].

In order to provide secure work opportunities within the various domains of work, an occupation must first have its services defined as essential for the approved operation of that domain. Section 54 of Part 3 of the **Hospitals Act** entitled "Hospitalization Benefits Plan" stipulates that "insured services": (1) shall be provided by "approved" hospitals or "any other institutions or persons that are prescribed in the regulations" [HA: s54(1)(a)(b)] and they: (2) shall include (a)"standard ward services" and (b) "any other goods and services that are prescribed in the regulations" [HA: s54(2)(a)(b)]. Standard ward services include the more usual mandated nursing and diagnostic services, in addition to physiotherapy services where "facilities are available" [HA: s53(j)(viii)] and "services rendered by persons who receive remuneration therefore from the hospital" [HA: s(53(j)(ix)]. Standard ward services are therefore insured services when they are performed within an approved facility [HBR: s2(b.1)] whose physical plant, equipment and operating expenses may be funded by the provincial government.

The Alberta Hospital Association also administers a privately funded, prepaid health care insurance plan (Alberta Blue Cross) which covers the cost of some "hospital and other health care services" [AHA: s9(1)]. For the purposes of funding, health services are defined as "basic", "extended" and "optional" health services. [HIA: s1(m)]. Generally speaking, basic health services are insured services [HIA: s1(a)(i)] when they are so specified in the regulations [HIA: s1(a)(vii)]. Extended services are goods and services, or classes of goods and services that are also specified in the regulations, or are funded services that are provided mainly to residents sixty-five years of age or older and their dependents [HIA: s1(w)(j)]. However, these services may be insured by a private insurance carrier for an individual, prior to his becoming sixty-five [HIR: s31(3)]. Optional health services are those goods and services or classes of goods and services that are considered to be optional to adequate health care [HIA: s1(q)] but these could conceivably be privately insured.

The Alberta Blue Cross plan, like other private insurance plans, covers the cost of basic and extended services in excess of that paid by the Alberta Health Care Insurance plan [HIA: s17(4)]. These private plans may not however, insure government prepaid basic or extended health care services or any portion of that cost [HIA: s17(2)]. To do so is considered a criminal act [HIA: s17(3)] and is backed by stiff legal sanctions [HIA: s38]. These private insurance plans may also cover the entire cost of the services defined as "optional" and are not covered by the government funded insurance plan [HIA: s27(g)(i)].

To administer the Alberta Blue Cross insurance plan, the Alberta Hospital Association establishes a Board of Trustees and appoints all but one of its members; the Lieutenant Governor in Council appoints the other member [AHA: s9(3)]. The Board of Trustees then may enter into contracts with hospitals and with other groups providing these stipulated hospital services and other health care services. [AHA: s10(3)(c)]. To cover payments for these services, the Alberta Hospital Association must establish a separate fund [AHA: s10(3)(d)] which the Lieutenant-Governor-in-Council may audit or inspect at any time [AHA: s10(8)]. This then, is another government established and monitored group which influences the structuring and funding of the domain.

The Blue Cross coverage of the cost of "optional" services or the additional funding of "basic" and "extended" health care services has more of an impact on the provision of health care services within specific health care programs and private practices and will be discussed more explicitly under those titles.

The **Coordinating Home Care Program Regulation** states that the program may provide "rehabilitation services" [HCR: s2(4)(a)] which include physical therapy and respiratory therapy services [HCR: s1(h)]. The program will also fund such goods as dressings, medications [HCR: s2(4)(b)] and health aids if these aids are not funded by another program, Act or insurance scheme [HCR: s2(4)(c)]. To be admitted to the programs, a doctor's recommendation is required [HCR: s3(1)(a)] but the administrator of the program actually admits the individual based on cost, as well as other criteria [HCR: s3(1)(b)]. A patient refused admission by this manager may appeal the decision to the local board of health [HCR: s3(5)].

It is a different government authorized individual who may or may not be a physician [ADL: s4(1)], that admits a client to another government program, "Alberta Aids to Daily Living and Extended Care Benefits" [ADL: s4(1)]. This government program pays for the services, supplies or appliances required by an individual with a disabling chronic condition either as a health "aid" to younger individuals [ADL: s2(2)(w)], or as a health "benefit" mainly to those 65 years or older, as well as to their spouses and dependents [ADL: s2(2)(b)]. Since many of the services of these two paramedicals are required by individuals with chronic conditions, this program funds much of the supplies and appliances they may require in the delivery of their services, in addition to the services that they provide [ADL: s1(e)].

Any resident of Alberta can also enter into a contract for privately funded insurance such as Alberta Blue Cross, which may cover the cost of "extended" services that exceeds the prescribed limit funded by the government plan [HIR: s31(1)(c)]. That is, if an older individual has private insurance covering these "extended" services, he must pay for them from that insurance before he is eligible for government funding [HIR: s31(3)]. However, this government program "Aids to Daily Living and Extended Care Benefits" will cover the expenses of patients who require the health care services but who are not covered by other Acts or private insurance [ADL: s2(3)]. Therefore, required supplies as well as the services of these two paramedicals are most likely to be funded in some manner within government programs.

Other than advising the Minister on defining what conditions are to be labelled chronic [ADL: s1(b)] and being one of the many types of authorizers [ADL: s4(1)], physicians do not have any formal decision making powers regarding the program. It is the Minister who designates among other things, the types of aids and benefits to be provided [ADL: s3(a)], the additional criteria to be met [ADL: s3(b)] and the cost to be paid by the individual [ADL: s3(e.1)]. The final appeal of his decision is made to a board that he appoints [ADL: s4.1(1) & s 4.1 (5)].

Both these programs are regulated under the Public Health Act which establishes a local board or health unit which among other things, is charged with the provision of treatment, rehabilitation and palliative services, supplies, and equipment that the regulations require [PHA: s20(a)]. These regulations may, as we have seen, include physiotherapy and respiratory services. The Local Board which administers these services [PHA: s17(g)] must appoint a physician as a medical officer of health [PHA: s17(d)] among other hired staff, and may delegate to these employees including the physician, the responsibility for carrying out these duties: i.e. the provision of supplies, and equipment as well as services [PHA: s18].

Interestingly, it is through the Home Care Program which R.T.members have been allowed a form of private practice that in turn, may contract its services to the program in order to fulfil its commitment of providing "rehabilitation services". Within the **Respiratory Therapy Regulations** and the **Health Disciplines Act**, there is no section that forbids a member of that occupation from owning his own practice and within the **Medical Profession Act** there is no specific legislation that directly forbids an R.T. member from owning his own practice. Section 44 of the **Bylaws of the College of Physicians and Surgeons** contains specific stipulations regarding "non hospital treatment and medical diagnostic facilities" and require that no person or corporation shall have ownership over the "practice of medicine" [MPB: s44(2)] which is then defined as:" the professional business of medical diagnosis, advice and treatment conducted by a registered practitioner..." [MPB: s44(1)]. R.T. members are not allowed to diagnose, as seen in the gate-keeping restrictions, and do not perform the same treatment services as physicians, as defined in their scope. Therefore neither this Act not its Bylaws apply to them directly.

However, another section within the **Medical Profession Act** may indirectly affect their right to have a private practice. Subsection 93(1) applies to diagnostic and treatment facilities in which physicians work, other than those institutions operated by the various levels of government and those that are government approved hospitals. The medical profession may appoint a committee to investigate these facilities and their financial arrangements [MPA: s93(2)]. If this committee does not approve the non government facilities, and if a physician continues to "see and treat" patients there, he will be found to be guilty of "unbecoming conduct" [MPA: s93(6)]. The punishment for "unbecoming conduct" may be to strike that member's name off the medical register, effectively rendering him unable to practice medicine [MPA: s56(1)(a)].

Furthermore, the Lieutenant-Governor-in-Council on a recommendation of the Minister, may request the Registrar of the Health Disciplines Board to inspect any practice of a registered member to see if the regulations of that discipline such as R.T., are being complied with [HDA: s29.1(1)].

P.T. members from the terms of their occupational act, have the legal right to own their own private practice in Alberta. The name of the practice is placed on a Physical Therapy held "Register of Corporations" [PTA: s21]. The private practice may remain on this register only if it continues to comply with terms established within this Act. They apply, among other things: to the "legal and beneficial ownership" of the practice [PTA: s23(f)], to the operational compliance with bylaws of the Act [PTA: s23(d)] and to the rule requiring a corporation to exclusively employ P.T. members in practice [PTA: s23(g)].

As described earlier, health services are classified as either "basic", "extended" or "optional". "Insured services" on the other hand, are any of these services which are declared to be insured [HIA: s1(n)]. Interestingly, nothing in the Act prevents an individual from paying for any of the health care services themselves if they don't want to use government insurance [HIA: s12(2)]. Within the **Alberta Health Care Insurance Regulations**, physical therapy services are generally classified as "basic" health services [HIR: s1(5)]. The specific physical therapy services that are to be insured, are those listed in the **Physical Therapy Benefits Regulation** [HIR: s1(k)(i)(A)]. A physical therapy practitioner is an individual who is entitled to practice under the **Physical Therapy Profession Act** [HIR: s1(1)(j.1)]. Therefore, P.T. services in private practice may be insured by government. However, the private practice will not be funded for items such as the administration of the practice [PTB: s7(d)], the bookkeeping required [PTB: s7(e)] nor the setting up of equipment [PTB: s7(g)].

The **Medical Profession Act** does not affect this paramedical's rights in his own private practice, for it is stated within a section of the **Medical Profession Act**, that says that: "nothing in this Act applies or affects a person practising under the authority of another Act of the Legislature" [MPA: s78(2)]. However, the Physical Therapy Council has the right to pass its own by-laws designating which clinical facilities will be accredited [PTA: s74(x)]. And it may initiate regulations regarding the conditions, restrictions and limitations of these practices [PTA: s73(e)].

(b4) income structure

A description of how paramedicals are paid for delivering their services within hospitals is not complicated since R.T. members and P.T. members are salaried employees of the hospitals. The salary levels of these employees have created much controversy since the combined salaries of all paramedicals represents a substantial portion of total health care costs. It should not be surprising then, to note that the Minister has the right to fix the level of salaries paid to employees of Provincial General Hospitals [PGHA: s14] These hospitals include, among others, the Foothills Hospital in Calgary and the Glenrose in Edmonton [PGHA: s2(1)]. Employees of other health care institutions negotiate their respective salaries in a more informal way, usually through a bargaining process between the Health Services Association of Alberta which represents both P.T. members and R.T. members, and the Alberta Hospital Association. One of the formal stated purposes of this association is to enter into "discussions and negotiations" between its members and their employees or "agents of their employees" [AHA: s5(d)]. The provincial government's legislation in this instance, only indirectly affects this process by legally forbidding the use of the usual employee bargaining tool held in reserve, the right to strike.

Governmental power in establishing and regulating health care programs has been described in the "domain of work" dimension. It was shown under that subheading that the Minister has great power in deciding the level of funding for these programs and that government-appointed officials including a few physicians, have discretion in administering them. But there are also no formal regulations as to how the paramedicals will be paid within these programs. Hypothetically, they could either be paid as salaried employees or on a contract basis. Presumably salaried R.T. members and P.T. members would be paid salaries at a similar level as those employed in hospitals, while those working on a contract basis would have payment for their services negotiated between themselves and their employers. Therefore, within provincial government health care programs, there are many informal negotiations taking place between the employees and employers over the remuneration for services giving more informal control to the administrators of the programs. These administrators are government appointees; a few of which may be physicians. For example those physicians who are mandated members on the local boards of health.

Terms within the **Physical Therapy Benefits Regulations** of the **Alberta Health Care Insurance Act** formally specify the conditions under which P.T. services performed within private practices will be funded by that plan. PTBR, section 1 concludes that benefits will be paid for physical therapy services provided by a physical therapist, thus reinforcing P.T.s legislation on other control dimensions. These benefits will only be paid if the patient has been referred by a physician, thus strengthening the gate-keeping restrictions placed on the provision of those services [PTBR: s4]. More specifically, these services will be paid by billing units based on "categories of supervision" routinely employed to provide P.T. services to patients [PTBR: s8] and not on a straight fee for service basis. These billing units are based on the categories of supervision required either for services given by the P.T. themselves [PTBR: s8(1)] or required when equipment is used to assist the P.T. [PTBR: s8(3)]. Services provided by a P.T. member in a private practice will not be funded if they are given in an institution owned, operated or funded by the provincial government or in a private house [PTBR: s7(a)].

P.T. members may claim benefits for their services according to the classification categories

[PTBR:s(1)(a)&(b)] and the range of services includes assessment, education and instruction of the patient [PTBR: s6(2)(a)] or of a person assisting the patient [PTBR: s6(2)(b) but only while the patient is present. They may not claim benefits for time spent in consultation with the referring physician [PTBR: s7(f)]. There are also limits placed on the dollar amount of benefits to be paid per patient or per family, either per day [PTBR: s3(2)] or per year [PTBR: s3(2)].

As both paramedical occupations operate within the medically defined health care system, it is necessary to examine the fee for structure of the physician whose own services relate to these paramedical's services. Section 25 of the **Medical Benefits Regulations** of the **Alberta Health Care Insurance Act** specifically asserts that specialist benefits are payable only to a specialist who is defined as such in the **Medical Profession Act**. The medical profession by-laws indicate that specialist certificates may be granted in both Respiratory Medicine [MPB: s39(a)(i)(v)] and Physical Medicine and Rehabilitation [MPB: s39(a)(i)(s)].

Within the **Medical Benefits Regulations** then, the procedures to be funded on a fee-for-service basis for respiratory services are headed "respiratory" and "vilalometry". Subsubsections B-80 to B-444 specify types of technical procedures and interpretations which one must conclude, are performed exclusively within hospitals since these are stipulations of very technical types of procedures which would require the use of highly technical and expensive equipment. There are no funding specifications for that equipment. Subsections D-1 to D-28 do the same for anaesthetic services, with the added specification of funding for different forms of consultations [MPBR: s D-1&D-2]. Again one must assume most of this work takes place within the hospital. The related R.T. members working within health care institutions are salaried.

While this income structure may be similar to P.T. members working in hospitals, it is not true of P.T. members working in their own private practices where their own services are funded. The P.T. member's control in private practice both interacts and challenges some of the services of the physician specialist in this area and can be seen within the fee-for-service funding limitations of each occupation's services. This funding reinforcement can be found in the **Physical Therapy Benefits Regulations** and the **Medical Benefits Regulations**. Physician specialists generally have consultative services funded whereas, the P.T. members do not. These consultations range from major consultations which may require a complete assessment of the patient including diagnostic procedures [MPBR: sV-1], through intra-specialty consultations with the referring physician [MPBR: sV-6], to conferences with the medical team and family [MPBR: sV-30]. P.T. members are not paid for the same services. In addition, these funded services may take place in the physician's office during office hours [MPBR: sV-601 to V-604], in the patient's home at any time [MPBR: sV-605 to V-609b] and within the hospital at any time [MPBR: sV-611 to V-613b]. P.T. services of a similar nature will not be funded when provided in a private home or government institution..

CHAPTER VII: ANALYTICAL DESCRIPTION OF LEVEL II: DIMENSIONS OF CONTROL WITHIN THE POLITICAL MARKETPLACE

A. INTRODUCTION

The last chapter analyzed the formal documents of Physical Therapy and Respiratory Therapy according to the seven dimensions contained in the first level of the framework. In this chapter, the analysis is continued by applying the second level of the framework to the relevant documents. It takes the reader through the remaining dimensions of the framework focusing on the institutional structure of the political marketplace as it relates to health occupations. As in the preceding chapter, the organization of this chapter follows the schematic presentation of Figure 5 on Chapter V.

As the reader will discover, the political marketplace is a very complex structure of many agencies and interagency networks which have different jurisdictions, with different administrative and governing rights. The strategy of the analytic description as guided by the framework, is to trace the lines of occupational control outward from the occupation to the source of state authority and from a jurisdiction focusing on paramedical register activities to the entire health care system. The final authority to grant control resides in the state Legislative Assembly but is delegated back to the occupations through enabling legislative terms. While the description may seem long and tortuous, it is hoped that in the end, the reader will have a clearer understanding of how Respiratory Therapy and Physical Therapy are formally positioned within the political marketplace.

B. ADMINISTERING RIGHTS

(a1) register management

For physical therapists in 1988, the Registrar of the Physical Therapy Council issued both the certificate of registration [PTA: s18(2):P.T.Act] and the annual certificate of renewal [PTA: s19(2)]; and it issued a permit to a corporation [PTA: s23(1)] annually [PTA: s23(2)]. Furthermore, the Registrar may issue specific registration certificates to be admitted as evidence in court [PTA: s70(a)] and will permit the public to inspect the registers [PTA: s13(2)].

This Registrar is appointed by the Council of the Physical Therapy College [PTA: s12] but no qualifications appear to be formally specified. The membership of this Physical Therapy Council consists of at least one member to be appointed by the Minister [PTA: s10(1)(b)] who may pay for this member's expenses [PTA: s10(5)], and at least eight members who are elected in accordance with the physical therapy council's own by-laws [PTA: s10(1)].

Decisions are passed on to the Registrar prior to his entering a name on the register, by the Registration Committee for initial registration [PTA: s18(1)(a)] and the Discipline Committee for suspension [PTA: s26(2)] or cancellation [PTA: s26(4)]. The Council itself may direct the Registrar to reinstate a physical therapist, registered practitioner or physical therapy corporation [PTA: s28(5)(a)] and to re-issue a certification of registration, annual certificate [PTA: s28(5)(b)(i)] or permit [PTA: s5(b)] when its delinquent fees and a reinstatement fee are paid [PTA: s28(5)].

Of the two groups that advise the Registrar, the Discipline Committee has its composition specified in the act while the Registration Committee must just be established with its members appointed by the Council [PTA: s14(1)]. This Discipline Committee must have one public member appointed by the Minister from a list of names submitted by the Council [PTA: s36(1(b)] and he may pay for his expenses [PTA: s36(4)]. The other members are to be knowledgeable members appointed directly by the P.T.Council [PTA: s36(1)(a)].

The 1988 regulations for Respiratory Therapy establish a different situation. As noted in the preceding chapter, their members and activities are administered under an R.T. Committee/Health Disciplines Board relationship [RTR: s1(b)]. It is the Registrar of the Health Disciplines Board who issues the annual certificate to R.T. members [RTR:

s3(1)]. The registrar does not have any formally defined qualifications. A subsection of the **Health Disciplines Act [HDA: s16(3)]** states in a more general way that the Registrar is responsible for issuing the registration certificate annually and he shall permit public inspection of the register during regular office hours [HPA: s11(2)]. The Health Disciplines Board oversees the management of the R.T. register [HDA: s27(e)], in addition to appointing the Registrar [HDA: s8].

The R.T. Committee can advise the Registrar on applications for registration [HDA: s6(a)] and will assess questionable applications prior to the granting of a license by the Registrar [HDA: s6(e)]. This Committee's members are appointed by the Minister; the term for each member is also prescribed by the Minister [HDA: s5(2)]. The majority of the committee members must be registered members of respiratory therapy and the rest must be 'knowledgeable' of that discipline [HDA: s5(2.2)]. The Registrar acts as a secretary to the Committee [HDA: s5(5)] and any member who is not a government employee will be reimbursed for his services and for his expenses by the Minister [HDA: s5(9)]. The Minister will also provide necessary supplies and services for this committee. [HDA: s5(12)].

(a2) register administration

Again, it is the Registrar of the Health Disciplines Board who must be satisfied that the individual applying for initial registration as a Respiratory Therapist has met the required educational, individual and fee occupational credentials [HDA: s13]. Once registered, the member must annually renew this registration [HDA: s16(1)]. Furthermore, any person who has a complaint with respect to any term of the R.T. code of ethics may write the Registrar concerning a member's "skill and judgement", their "fitness to practice" and "conduct in practice or otherwise" [HDA: s18(1)(a)]. A complaint may also be made to the Registrar if a member is thought to be providing services other than those authorized [HDA: s18(1)(b)].

The Registrar may also inspect the private practice of a member at the request of the Lieutenant-Governor-in-Council on a recommendation of the Minister [HDA: s29.1(1)]. If he concludes that unbecoming conduct, lack of skill or lack of judgement has occurred within this practice [HDA: s29.1(5)(b)] and if the member does not implement required remedial action [HDA: s29.1(7)], the Registrar himself will initiate a complaint to be dealt with by the R.T. Committee [HDA: s29.1(6)].

If the Registrar is not satisfied with the application for initial registration, he will refer it to the R.T. Committee [HDA: s4(1)] and it will review this application [HDA: s14(2), 15(2)]. With regard to renewal, if the member has not practised in the discipline or does not meet the continuing education requirements, the Registrar will also refer the application to the R.T. Committee for further assessment [HDA: s16(3.1)]. Following a complaint, the Registrar or his appointee will conduct a preliminary investigation [HDA: s18(2)] and provide a report of his findings to the R.T. Committee [HDA: s18(5)] which will then investigate the complaint [HDA: s6(6)]. The Committee then must decide whether the complaint is frivolous or whether to hold a hearing [HDA: s20(1)(a),(b)].

Sanctions that may be imposed by the Committee if the complaint is upheld, range from a reprimand [HDA: s20(9)(a)] to payment of a fine [HDA: s20(9)(b), to conditions and restrictions placed on the member's ability to practice; or sanctions that require him to take further training [HDA: s20(9)(g)] and most drastically, that suspend his license [HDA: s20(9)(c)] or cancel his registration [HDA: s20(9)(d)]. The Committee will send written copies of its decision to the person charged, the complainant and the Registrar [HDA: s20(11)]. Since a license is not a requirement for employment, it is further stated within the Act that the member may not practice until the suspension is expired or revoked [HDA: s22].

It is the Health Disciplines Board that appoints the Registrar [HDA: s8]. If a disciplined member is not satisfied with the judgment, he may request the Health Disciplines Board to review decisions of: denied initial registration [HDA: s23(1)], denied renewal of registration

[HDA: s23(2)] or the cancellation of registration [HDA: s23(3)]. Finally, any party involved in any of the types of register administration proceedings, may appeal any of the decisions to the Courts [HDA: s25(1)(1.1)]. The registration and renewal fees are paid to the Provincial Treasurer [HDA: s27(1)(n)].

For P.T.s there is an interplay between different occupational bodies regarding the administration of their register in that the Council must establish the Registration Committee [PTA: s14(1)] and the Registration Committee may in turn, delegate some of its authority to the Registrar [PTA: s14(2)]. Section 19 of the Act states that a physical therapist will pay an annual fee to the Registrar or anyone he authorizes [PTA: s19(1)]. In both the Act and Regulations though, it is the Registration Committee that may refuse to register the member or to grant his annual certificate and to place the conditions for their approval [PTA: s15(2); PTR: s6]. Member registration and corporate permit fees are paid to the P.T. College [PTA: s74(1)(n)].

Specifically, a person applying for initial registration and for an annual certificate must apply to the Registration Committee [PTR: s5(1); & 6(1)]. A person given a conditional right to practice by the Registration Committee [PTR: s6(3)(b)] will be placed temporarily on the Special Clinical Practice Register [PTR: s6(5)(W)]. Similarly an individual applying to register on the

Educational Register must also apply to the Registration Committee for approval [PTR: s8(1)]. The applicant may appeal the Registration Committee decisions to the P.T. Council if the decision involves refused or deferred registration [PTA: s16(5)].

The Registrar must also be satisfied that the requirements for a corporate permit are being met [PTA: s23]. However, it is the P.T. Council that actually suspends, cancels or withholds the permit [PTA: s23(3)] when the corporate occupational credentials are not being met.

Another body, the Discipline Committee, must be established to determine who may remain on the register following a complaint of a member's conduct [PTA: s36(1)]. Generally speaking, it is the duty of a physical therapist, registered practitioner or physical therapy corporation to report any conduct that violates the terms of the **Physical Therapy Act, Physical Therapy Regulations** and By-laws [PTR: s11(1)(c)].

If the Discipline Committee finds a violation, it may impose one or more of the following sanctions ranging in seriousness from [PTA: s54(1)]: a reprimand; to a suspension of the certification of registration, annual certificate or both, either generally or from a specified field for a specified time; to the cancellation of the certificate of registration or the annual certificate of a member; or the cancellation or suspension of the permit of a corporation

[PTA: s54(1)(a)(b)(j)(k)]. Furthermore, the Committee may order fines in addition to, or instead of, the previous sanctions. Such fines must be paid the College of Physical Therapists [PTA: s55(1)]. If these fines are not paid, the member may also have his certificate of registration or annual certificate suspended [PTA: s55(2)].

The investigated member or the College may appeal the findings and sanctions imposed by the Discipline Committee to the Council of Physical Therapists [PTA: s61(1)]. Subsequently, the investigated person or the College may appeal the Council's decisions to the Court [PTA: s64(1)].

It is another Council appointed body that must be established [PTA: s32(1)], the Practice Review Board, which may, at the request of the Council or on its own initiative, investigate the "practice of a physical therapist, registered practitioner or physical therapy corporation" with regard to its "competence in practice" [PTA: s33(1)(b)]. If this Board concludes that the conduct in question is a case of "unskilled practice" or "professional misconduct", the case will be referred to the Registrar who will deal with it as if the charge was a formal complaint requiring a hearing under the discipline proceedings [PTA: s34(1)(d)(i)].

A member may apply to the Council for reinstatement of a cancelled registration [PTR: s22(1)] and the Council may establish yet another body, a Commission of Inquiry, to investigate and make recommendations to the Council regarding this cancellation [PTR: s22(2)]. It will eventually produce a written report for the Registrar [PTR: s24(1)] who will send copies to the member applicant and to the Council [PTR: s24(2)]. The Council has the right to reinstate the member and apply any terms or restrictions it wishes [PTR: s24(4)]. The membership of the Committee of Inquiry for reinstatement is not specified, other than to say that a member of the preliminary investigation, Discipline Committee or Council involved in the cancellation of registration may not be on the Committee of Inquiry [PTR: s22(3)].

The certificate of registration, annual certificate or permit of a physical therapist, registered practitioner or physical therapy corporation is suspended following the ruling of any Physical Therapy administrative body [PTA: s26(1)]. The member without a certificate of registration, annual certificate or permit cannot practice nor professionally associate with anyone still on a register [PTA: s75]. If he continues to behave as if he is in good standing, he will be charged with professional misconduct [PTA: s67]. No employer, or anyone else, can ask a suspended member to provide physical therapy services that contravene an order, direction or decision of the Discipline Committee, Council or Court [PTA: s68].

Furthermore, an occupation achieves more occupational control if it is to be able implement the terms of its occupational legislation. Some of the control exercised by the P.T. occupationally-controlled Council has been already been detailed using terms found within the P.T. act and regulations; for example, the Council's ability to establish committees, appoint members and hear appeals from the decisions of the various groups. Sections 73 and 74 of the **Physical Therapy Profession Act** provide the basis for suggesting that the jurisdiction of this P.T. body also includes the ability to oversee many of its own activities. That is, it has the right to initiate regulations within the jurisdiction detailed in section 73, subject to a majority member vote and Lieutenant-Governor-in-Council approval [PTA: s73(1)(2)(a) & (b)]. It also has the right to pass by-laws within the jurisdiction detailed in section 74, subject only to a majority members vote [PTA: s74(2)]. The terms of the regulations are legally binding on all members [PTA: s37(1)(b)] while by-laws terms are legally binding on the members being investigated [PTA: s37(2)] in that violation of any of these terms constitutes "professional misconduct".

In summary, with respect to Physical Therapy and the right of the P.T. Council to implement its own occupational legislation: This Council has the right to initiate by regulation, the procedures for registration and the review of complaints [PTA: s73(1)(i)] as well as the establishment of "committees of inquiry" to investigate the reinstatement of a member [PTA: s73(1)(m)]. It may initiate regulations concerning the evaluation and examination of the applicant's register qualifications [PTA: s73(1)(c)], the procedures to be followed by the Registrar or his appointee, the Practice Review Board, the Discipline Committee and the Council in the investigation of a members's conduct [PTA: s73(1)(f)] and by the Practice Review Board or its appointee in the investigations of a member's practice [PTA: s73(1)(h)]. It may initiate regulations concerning the costs to be paid to the College after an investigation by the Discipline Committee or College [PTA: s73(1)(g)] and the manner in which the publication of cancellation or suspension will be carried out [PTA: s73(1)(k)]. This specific control is in addition to its right to initiate regulations to set the standards of: a code of ethics [PTA: s73(1)(a)], character requirements [PTA: s73(1)(b)], standards of practice [PTA: s73(1)(d)], compulsory continuing education programs [PTA: s73(1)(j)] and the requirements needed for the annual certificate [PTA: s73(1)(q)], among other things.

Furthermore, the Council may set by-laws for the appointment of: members of the Discipline Committee and Practice Review Board [PTA: s74(1)(f)], members of other committees and boards [PTA: s74(1)(g)], of the Registrar and some of his added responsibilities [PTA: s74(1)(i)], as well as the members and officers of the Council itself, and the officers of the College [PTA: s74(1)(d)]. These rights are in addition to the right to set the responsibilities of the College [PTA: s74(1)(a)]. Other types of control the Council may prescribe through by-laws concern: the categories of membership in the College and the responsibilities of members within each [PTA: s74(1)(h)] and the fees payable to the College by members of the different categories [PTA: s74(1)(n)]. With regard to the supply of its services, the Council has the right to designate which clinical work sites are to be "accredited" [PTA: s74(1)]. The College in this case, is the College of Physical Therapists of Alberta [PTA: s1(d)] and the Council is the Council of the College [PTA: s1(e)].

In summary, with respect to Respiratory Therapy and the right of the R.T. Committee's ability to implement its own legislation: The R.T. Committee does not have the right to initiate, change or pass any occupational regulations. The Health Disciplines Board has these rights and this power will be detailed in the next sections. The committee itself, does have the right to pass rules or by-laws "governing the calling and the conduct of its meetings and any other matters pertaining to its business and affairs" [HDA: s5(10)] keeping in mind the Board monitors these activities [HDA: s7.9(1)(a)].

(a3) administrative responsibility by government

As shown above, the Health Disciplines Board, a government body, has a great deal of power over R.T.

activities. In contrast, the Physical Therapy Council, an occupational body, oversees the occupational activities of P.T.. However, the P.T. Council must still submit an annual report to the Minister of the Department of Hospitals and Medical Care on "the business and affairs" of the Physical Therapy College [PTA: s9(3)]. Therefore, the government agency that directly oversees R.T. activities is the Health Disciplines Board and the one that indirectly oversees P.T. activities is the Department of Hospitals and Medical Care. The latter department also directly oversees the funding of supply of services of both occupations; this is also the case for the Department of Community and Occupational Health.

Terms within the **Health Disciplines Act** stipulate that the members of the Health Disciplines Board are appointed by the Lieutenant-Governor-in-Council [HDA: s3(1)]. Of the seven to nine members, two must be from the College of Physicians and Surgeons and one must be from the Alberta Dental Association [HDA: s3(1)(a)]; the rest are undefined by occupation [HDA: s3(1)(b)]. Member services and Board functions are financed by the Minister [HDA: s3(13)].

The Board has the right to initially investigate whether an occupation qualifies for legislation by this route [HDA: s4(1)]. Either the occupational association must apply for this legislation [HDA: s4(1)(a)] or the

Minister may direct the Board to investigate this possibility [HDA: s4(1)(b)]. Since the prime consideration guiding this investigation by the Board is whether harm will come to a patient if the occupation is not legislated under the **Health Disciplines Act** [HDA: s4(5)(a)], the Board will examine such detail as the control these occupations currently have of their services as found in Level I of the framework. If the Board decides that there is potential for harm under the current arrangements, it will submit a report to the Minister recommending the paramedical occupation be legislated as a "designated health discipline" under the **Health Disciplines Act** [HDA: s4(5)(a)].

Once the Board has recommended to the Minister that a paramedical occupation be legislated under the **Health Disciplines Act**, the Board will then initiate regulations to specify the paramedical's registered name and abbreviation [HDA: s27(1)(m)], the services to be included in its regulated scope of practice [HDA: s27(1)(a)] and the gate-keeping rights or restrictions placed on the delivery of these services [HDA: s27(1)(b)]. And the Board may initiate the regulations related to a paramedical's business [HDA: s27(u)]. With regard to occupational credentials, it can prescribe the qualifications for initial registration [HDA: s27(c)] including the obligatory training programs [HDA: s27(h)] and examinations [HDA: s27(i)]. It can prescribe the necessary requirements for the renewal of registration

[HDA: s27(k)] and the requirements for upgrading competency [HDA: s27(l)]. The Board can also prescribe the occupation's standards of conduct and competency [HDA; s27(f)] as well as the information the Registrar puts on the annual certificate [HDA: s27(g)]. The Board prescribes the separate registers that must be established for each occupation legislated under the Act [HDA: s27(e)] as well as any temporary registers [HDA: s27(o)] and their restrictions [HDA: s27(p)]. Very little power is given the Board to prescribe the terms of register administration other than to stipulate the date by which the applications and renewals of membership must be submitted [HDA: s27(g)].

Before making any decisions as to whether to legislate the occupation under the **Health Disciplines Act**, the Board consults any other associations who have a stake in the delivery of these services [HDA: s4(2)]. On becoming a designated health discipline, one of the important terms of the legislation for the occupation is whether this paramedical's corporate body relationship to the board will be in the form of an Association/Board or Committee/Board. The Minister specifies this [HDA: s4.2] on recommendation of the Board [HDA: s4.1(1)].

The R.T. Committee in this case [RTR: s1(b)], has only the right to advise the Board on: the services to be provided by its members and the limitations or conditions to be placed on that delivery, i.e. on issues of scope and gate-keeping [HDA: s6(c)]; on the type and level of qualifications and training felt to be necessary, i.e., on occupational credentials [HDA: s6(f)], and its expected level of standards and competency required for continued practice, i.e., its code of ethics [HDA: s6(d)]. However, the R.T. Committee has important control over the administration of its register in that it may advise the Registrar on applications for membership [HDA: s6(a)] and it may investigate complaints of its members' unprofessional conduct or incompetency [HDA: s6(b)].

The Health Disciplines Board is a creation of the **Health Disciplines Act** and the Act is administered by the Minister of the Executive Council that is responsible for it [HDA: s1(e)]. To summarize and to repeat for clarity: the Minister may among other things, direct the Board to investigate an occupation for possible inclusion under the terms of this Act [HDA: s4(1)(b)]. He can then specify whether the health discipline will be governed by a Committee or Association relationship with the Board [HDA: s4.2(a)&(b)] and if by Committee, the Minister will establish it [HDA: s5(1)(a)] and appoint its members [HDA: s5(2)], among other things. To assist the Board, the Minister may establish Advisory Committees he feels are necessary to administer the Act and its regulations [HDA: s4.01(1)]. He appoints its members [HDA: s4.01(2)(a)] and finances its operation [HDA: s4.01(2)(d)]. The Registrar of the Health Disciplines Board must submit an annual report to the Minister on the activities of the Registrar, the Health Disciplines Board, occupational committees and associations [HDA:s11(3)].

None of the regulations initiated by the Board become a legal requirement unless passed by the Lieutenant-Governor-in-Council [HDA: s27(2)]. The Lieutenant-Governor-in-Council retains the right to approve, vary and then approve, or disapprove any of these proposed regulations [HDA: s27(3)(a),(b),(c)]. And the Lieutenant-Governor-in-Council, on a recommendation of the Minister, may direct the registrar to inspect the practice of a registered member for possible violations of the regulations [HDA: s29.1(1)].

Interestingly, the **1988 Annual Report** describes this Board as only an: "advisory body of Government whose function is to provide expertise and guidance in the regulation of health disciplines under the Act" [HDR:p 2]. In 1984, changes in the **Health Disciplines Act**, were thought to have extended the "decision making privileges" of the Board while changes in 1988, appear to add more complex administrative procedures [HDR:p 1]. For instance, there are now two types of Advisory Committees established to advise the Board: "Regulation Development Advisory Committees" and "Expert Advisory Committees" [HDR:p 2].

From the descriptions in the Annual Report, one can also more fully understand the entire jurisdiction of responsibility of the Board. The self-descriptive listing of its responsibilities range from: "Conducting Investigations of Prospective Health Disciplines under the **Health Disciplines Act**", through "Developing Regulations", "Approval of Educational Standards and Register Exams", to being the "Appeal Body for Registration Decisions and Complaint Decisions" and to "Monitoring Health Disciplines that are legislated under the Act" [HDR:p 4].

In 1988, the Chairman of the Board was a physician, Dr. J. Noakes. Of the other members, two have the prefix Dr. (one presumably being the mandated dentist) while the others were not identified by occupation [HDR:p 2].

Health Discipline Committees and Associations are generally described in the Report as being able to: "register practitioners, handle disciplinary matters and assist the Board in establishing and amending regulations" [HDR:p 2, p 7]. The Health Disciplines Board becomes an appeal board: "for decisions of health disciplines committees or health discipline associations" [HDR:p 7]. The Board and its committees are described as being: "assisted in their work by the Registrar of the Health Disciplines Board and other professional staff from the Alberta Professions and Occupations Bureau". Responsibility for the **Health Disciplines Act** remains with the "Minister Responsible for Professions and Occupations" [HDR:p 2].

This report was prepared in 1989 by the Professions and Occupations Bureau which describes the activities of the Board in 1988. It was submitted by the Registrar to the Chairman of the Council of Professions and Occupations [HDR:preface] and by that Chairman to the Minister Responsible for Professions and Occupations [HDR:preface].

Terms within the **Department of Hospitals and Medical Care Act** state only that a department will be established and that it will be administered by a "member of the Executive Council appointed by the Lieutenant Governor" [HMA: s2]. The terms vaguely specify its composition in that the Lieutenant-Governor-in-Council may establish two Deputy Ministers [HMA: s3(1)] and other necessary employees, all of whom will be civil servants [HMA: s3(2)(a)].

Generally, the Minister may give monetary grants on his own, if the terms within the regulations of the Act say that he may [HMA: s7(1)(a)]. However, terms within Section 9 of the Act allow the Minister to delegate any responsibility given to him in the Act, regulations or any other Act or regulation, to any employee of his department [HMA: s9(1)] except the right to prescribe regulations [HMA: s9(2)]. Furthermore, Section 1 of the **Hospitals and Medical Care Grants Regulation: Schedule General Grants** allows the Minister to give grants "for any purpose which relates to any program, service or matter that comes under the administration of the Minister". But again, the Minister may pass this responsibility on to a government employee who is under the administration of the Minister [HMGR: s2].

The Minister may seek the advice of experts to advise him "on matters under his administration" [HMA: s4(1)] and he will pay for their services and expenses [HMA: s4(2)]. He may also establish any "boards, committees or councils" he needs to advise him [HMA: s5(1)] but he will appoint its members [HMA: s5(2)(a)] pay for their expenses and fees [HMA: s5(2)(d)], among other things. These agencies will have the responsibility and power he prescribes or approves [HMA: s5(4)]. More importantly, terms within Section 6 of the Act permanently and legally establish a Hospitals and Medical Care Advisory Committee [HMA: s6(1)] to give advice specifically on "policies, programs and services or other matters under this agency's administration" [HMA: s6(2)]. The Minister will (a) appoint its members and (d) pay for their expenses and fees [HMA: s6(3)] while the Committee itself, will set its own rules of procedure for calling and conducting its meetings [HMA: s6(3)&(4)].

However, the Lieutenant-Governor-in-Council must pass regulations. For example, with regard to grants, he must pass regulations authorizing the types of persons or organizations eligible for the grants [HMA: s7(2)(d)], the conditions of eligibility for application [HMA: s7(2)(e)] and the method of repayment [HMA: s7(2)(f)], among other things. It must pass regulations that more generally allow the Minister to enter into an agreement concerning all matters relating to payment of the grant [HMA: s7(2)(k)]. The Lieutenant-Governor-in-Council may also pass a further regulation allowing the Minister to delegate these responsibilities for payment grants to any government employee [HMA: s7(2)(i)].

Since administrative activities are not specified in the Departmental Act or Regulations, they can only be ascertained in its Annual Report. According to the Report, the Department is divided into divisions of: Career Development, Hospital Services, Health Care, Finance and Administration, Policy Development and Information Resource Management [HMR:p.9]. But, it is through the description of administration of the various other Acts and Regulations that the more explicit range of this department's activities are found.

This jurisdiction can be seen in the summary of Statutory and Regulatory Changes. Under statutory changes, or changes in Acts passed by the Legislature, the Department of Hospitals and Medical Care changed sections of the **Hospitals Act**, the **Nursing Homes Act**, the **Alberta Health Care Insurance Act** and the **Alberta Hospital Association Act** [HMR: p5]. Regulatory changes passed by the Lieutenant-Governor-in-Council were implemented in: the **Alberta Health Care Insurance Regulations**, the **Alberta Hospitalization**

Benefits Regulations[1], the Basic Health Services Benefits Regulations[1], the Benefits Payable to Dental Surgeons Regulations[1], the By-laws of the College of Physicians and Surgeons Regulation, the Claim for Benefits Regulation,[1] the Chiropractic Benefits Regulation,[1] the Dental Benefits Regulation,[1] the Health Care Insurance Premiums Regulation, the Hospitals Districts Regulations, the Medical Benefits Regulations[1], the Medical Committee Regulations, the Mental Health Regulations, the Nursing Homes Operation Regulations, the Optometric Benefits Regulations,[1] the Payment for Out of Province Medical Claims Regulations, the Physical Therapy Benefits Regulations,[1] the Podiatric Benefits Regulations,[1] and the Registration Regulations of nurses [HMR: p5-8].

Changes in the acts such as the Hospital Act, generally affect paramedical activities. However, the non-legislature implemented changes in the regulations especially the various benefits regulations marked with a [1], directly affect the funding aspects of many health care occupations including physicians and six paramedicals. One of the six occupations is physical therapy. These regulatory changes in funding range from removing some services from a list of services that physicians may provide such as routine eye examinations [Medical Benefits Regulation] [HMR: p6] to eliminating some patient eligibility for optometric services

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[1] In this paragraph, the [1] is inserted to alert the reader that these items have special significance for funding.

[Optometric Benefits Regulations] [HMR: p7] and to reducing the funding limits for services provided by Chiropractic [Chiropractic Benefits Regulations], Podiatric [Podiatric Benefits Regulations] and Physical Therapy services [Physical Therapy Benefits Regulations],[HMR: p6&7].

A descriptive summary of the Alberta Health Care Insurance Plan further indicates that benefits are to be paid for medical and these other specified paramedical services, on a fee for service basis according to a pre-arranged schedule [HMR: p11]. Physical therapy services are listed as basic health services but are usually funded to limits of $200 per patient per benefit period. It is noteworthy there was no limit placed on the funding of approved services of physicians [HMR: p11]. The limits are waived for physical therapy services under special conditions in which the treatment is seen as a continuation of in-patient care or if the person is eligible for Extended Health Benefits. Extended Health Benefits under this plan are provided to persons older than sixty-five years or to widows and to both of their dependents, primarily for optical and dental goods and care. Other extended care benefits are provided through the Department of Community and Occupational Health [HMR: p12].

In addition to the fee-for-service funding of medical services, the Health Care Insurance Plan also funds Sessional Payment Programs as:" an alternative form of physician remuneration on a program basis" [HMR: p14]. And the Department of Hospitals and Medical Care through this plan, has further funded physician programs such as the Incentive Payments Programs to entice physicians to practice in rural Alberta [HMR: p14]; a Continuing Medical Education Program administered by the Alberta Medical Association which gives allowances to physicians normally paid on a fee-for-service basis to continue post-graduate education; and an Alberta Physicians Disability Insurance Program which is administered by the Alberta Medical Association for physicians of fee-for-service standing [HMR: p15].

Of the five top positions within the Department of Hospitals and Medical Care: Deputy Minister, Public Communications Assistant Director, Senior Policy Advisor, Senior Medical Consultant, and Profession Services Director - the last two were filled by physicians. The Minister was M.L.A. Marvin Moore, a non-physician [HMR: p9].

The annual report was published by the Department of Health in February, 1989 but contains information up to March, 1988. It was presented to the Minister of Health by the Deputy Minister of Health (not identified as a physician) and then by the Minister to the Legislative Assembly [HMR:preface].

This administrative structure in which the act of the provincial department includes specific terms and terms of "enabling legislation" to: establish the department [COA:

s2], staff it with government employees [COA: s3] and delegate the powers of the Minister to the employees [COA: s5], is repeated in the Department of Community and Occupational Health. Again the minister in charge is said to be the member of the executive council responsible for the department and is appointed by the Lieutenant Governor [COA: s2].

This Minister may also seek the services of experts [COA: s4] before entering into agreements concerning "any policies, programs, services or other matters under his jurisdiction" [COA: s6(1)] and may establish any "advisory or administrative boards committees or councils" that he feels are necessary [COA: s7(1)].

And, with regard to grant regulations, it is the Lieutenant-Governor-in-Council that may pass terms on funding [COA: s9(2)] which range from conditions supporting the grant applications [COA: s9(2)(c)], the purposes for the grants [COA: s9(2)(b)] and the persons or organizations who may apply [COA: s9(2)(d)] among other grant conditions. And it may authorize the Minister to delegate these responsibilities to a government employee [COA: s9(2)(i)].

It is from the Department of Community and Occupational Health's 1988 Annual Report that one must discover its actual activities. The administering responsibilities of the department can be seen in the list of its divisions: Family and Community Support Services*, Mental Health*, Occupational Health and Safety*, Public Health Division*, Human Resources, Management Support Services, Program Support Services and Communications Branch [COR: p5]. The four divisions that relate directly to the public are those starred. Of these, it is the Home Care Program and the Aids to Daily Living/Extended Health Benefits Programs of the Local Health Services Branch of the Public Health Division [COR: p3] that are pertinent here. Therefore, we are looking at two programs within a specific branch of a specific division of this department.

Other programs within the Local Services Branch include: Community Health Nursing, Early Intervention, Alberta Hereditary Diseases, Dental Branch, Speech Pathology and Audiology. The Local Health Services Branch is one of four branches of the Public Health Division, the others being: Health Program Development, Environment and Health, Communicable Disease Control and Epidemiology Branches [COR: p3]. The division has other responsibilities for things like communicable diseases, the environment and public health programs [COR: p3].

Homecare itself, is described as necessary to:"..provide health and support services to help people remain independently in their homes" and is provided mainly for senior citizens. Furthermore, the demand is seen as increasing rapidly with a four-fold increase in demand in the past four years [COR: p12]. Alberta Aids to Daily

Living/Extended Health Benefits are described as programs to assist chronically ill individuals with the cost of medical equipment and supplies so that they may remain "in the community" and these items may include: walking aids, orthotics and prosthetics and home oxygen equipment, among other things [COR: p12].

From the report: "The Public Health Division directs, co-ordinates and integrates activities in four major areas [those mentioned].." but services are "...provided through Alberta's 27 locally autonomous health units." [COR: p6]. Therefore, this department's administration of services through local units is very indirect and this trend will continue since one initiative taken by the division is to increase the flexibility of these units through global funding [COR: p6]. The membership of these local health care units was detailed earlier and includes one mandated physician.

As was the case with the Annual Report of the Department of Hospitals and Medical Care, this annual report was published by the Department of Health in February 1989 but concerned its activities to March, 1988. It was presented by the same deputy minister to the same Minister, who then presented it to the Legislative Assembly [COR:preface].

(a4). administrative co-ordination by government

In the preceding section, it was shown that the legislated authority of the Health Discipline Board and Physical Therapy Council could be traced through various government agencies to Provincial Ministers. In this section, we trace the lines of authority from Ministers through the complex interagency structure of government agencies to the Executive Council. This is done by indicating the agencies, boards and acts which fall under the jurisdiction of the Minister responsible for the Health Disciplines Board, the Minister responsible for the Department of Hospitals and Medical Care and the Minister responsible for the Department of Community and Occupational Health.

The Minister responsible for the Health Disciplines Board was also responsible for the: **Blind Workers' Compensation Act, Chiropractic Profession Act/Regulations, Dental Mechanics Act/General Regulations, Dental Technicians Act/Regulation, Forestry Profession Act/Regulation, Health Disciplines Act/Emergency Medical Technicians Forms Regulation, Emergency Medical Technicians Regulation, Medical Radiation Technologists Regulation, Nursing Assistants Regulation, Psychiatric Nurses Regulation, Respiratory Technologists Regulation, Occupational Health and Safety Act/14 Regulations[1], Ophalmic Dispensers**

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[1] with other departments

Act/Regulations. Pharmaceutical Association Act/ Rules, Regulations and By-laws of the Alberta Pharmaceutical Association, Pharmaceutical Profession Act:awaiting proclamation, Podiatry Act, Psychology Profession Act/Regulations, Radiation Protection Act, Radiological Technicians Act', Social Workers Act, and Workers Compensation Act/4 Regulations.

The Minister responsible for the Department of Hospitals and Medical Care was also responsible for the: Alberta Health Care Insurance Act/6 Regulations (including Medical Benefits Regulation), Physical Therapy Regulation, Alberta Hospital Association Act, Alcohol and Drug Abuse Act, Alcoholism and Drug Abuse Foundation Act, Calgary General Hospital Board Act, Cancer Programs Act, Department of Hospitals and Medical Care Act/Regulation, Health Facilities Review Committee Act, Health Insurance Premiums Act/Regulation, Hospitals Act/4 Regulations, Human Tissue Gift Act, Lloydminister Hospital Act, MSI Foundation Act, Medical Profession Act/Bylaws of the College of Physicians and Surgeons of Alberta, Nursing Homes Act/2 Regulations, Nursing Profession Act/Regulation, Occupational Therapy Profession Act, Optometry Profession Act/2 Regulations, Physical Therapy Profession Act/Regulation, Provincial General Hospitals Act, Radiological Technicians Act ', Registered Dietitians Act/Regulation, University Hospitals Foundation Act, University of Alberta Hospitals Act. The

Minister responsible for the Department of Community and Occupational Health was also responsible for the: Blind or Deaf Person's Rights Act, Change of Name Act/Regulation, Coal Mines Safety Act/Regulation', Dental Profession Act/Regulation', Department of Community and Occupational Health Act', Emergency Medical Aid Act', Family and Community Support Services Act/Regulation', Marriages Act/Regulation', Mental Health Act/5 Regulations, Nursing Service Act', Occupational Health and Safety Act/15 Regulations, Public Health Act/24 Regulations including Alberta Aids to Daily Living and Extended Health Benefits and Coordinated Home Care Program', Quarries Regulation Act, Radiation Protection Act/2 Regulations, Radiological Technicians Act', Vital Statistics Act/2 Regulations'.

With regard to co-ordination from the publication Inventory of Agencies, Boards and Commissions, 1988, one finds that minutes of meetings of the Health Disciplines Board "are restricted to internal use" [GAI: p113]. This is also true for the Hospitals and Medical Care Advisory Committee since their minutes are to be distributed only to members and department officials [GAI: p156] while the Public Health Advisory and Appeal Board's minutes of meetings are also "restricted internally" [GAI: p164]. However, the Departments of Hospitals and Medical Care and Community and Occupational Health must be notified of Health

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' now into the Department of Health

Discipline Board meetings [HDA: s3(7)].

From an organizational chart in the publication titled **Organization of the Government of Alberta: August, 1987** one can see that the departments of Hospitals and Medical Care and Community and Occupational Health are directly responsible to the Executive Council and the Premier. In addition, some Crown Corporations, Boards, Agencies, Commissions, Bureaus and Offices are directly responsible to the Executive Council. Included in this list is the Health Disciplines Board which is responsible to the Executive Council through the Minister I.W. Reid [GAI: p2].

This governing body, the Executive Council and Premier (the Cabinet) constitutes the Executive branch of the government [GAO: p2]. This body in 1987, consisted of at least twenty four members other than those in charge of these departments and board [GAO: p2]. That is, the provincial Cabinet consisted of at least twenty seven Ministers representing other departments with wide ranging interests such as Energy, Consumer and Corporate Affairs, Economic Development and Trade, Technology Research and Telecommunications and Treasury [GAO: p2].

(a5) administrative change by government

These dynamics of government and/or medical administrative control within the political marketplace over paramedical members and the supply of their services may also be seen in the output of a Royal Commission. The Royal

Commission as noted earlier, is a temporary government administrative agency capable of providing the basis and rationale for formal change.

A provincial royal commission entitled "The Premier's Commission on Future Health Care for Alberta" was established in December, 1987 [PCOC]. Its members consisted of a full-time Deputy Chairman who is a physician [PCRR3: p9]; a Chairman who is a lawyer and was an M.L.A. having held various cabinet positions including that of provincial treasurer [PCRR3: p9]; and five other members: a physician who was past president of the Alberta Medical Association [PCRR3: p10], a former laboratory assistant in physiology and biology who is also the mother and wife of physicians [PCRR3: p12], a university business graduate who had been a trustee of the University Hospital and had sat on a committee of the Faculty of Medicine [PCRR3: p12], a certified tradesman who had been active in various hospital associations both provincially and nationally [PCRR3: p11], a nurse who was the Dean of Nursing at the University of Calgary [PCRR3: p10] and a Roman Catholic priest who had been associated with various social work associations [PCRR3: p11]. At the beginning of their deliberations, the members split into three working groups with two commissioners on each. The members dealing with acute care which is an area especially important to paramedical control, were the physician who was past president of the

A.M.A. and the member who had been a hospital trustee [PCRR3: p26]. The members of the Commission were appointed by the Lieutenant-Governor-in-Council [GAI: p121] with the exception of the Deputy Commissioner who was a full-time government employee; their services were paid for through grants established by the Lieutenant-Governor-in-Council [GAI: p122].

The jurisdiction addressed by the Commission was to include:"future health requirements for Albertans", the planning, delivery and funding of future health care services taking into account, the roles, responsibilities and expectations of individuals and various groups including the medical and paramedical occupations; the maintenance of quality and access to these services; or any other relevant matter the commissioners wished to include [GAI: p121]. The commissioners enlarged the specified jurisdiction from initially seeing themselves as being required to make recommendations to ensure the countenance of "the best health care system" [PC188] to include recommendations for the maintenance of "a quality health system" [PC288] and furthermore, they found it appropriate to predict the social, legal, economic, education, environmental, political and technical aspects of daily life of an Albertan in the year 2000 [PC288]. "It is our judgement that we must adopt a broader approach to health..." [PCRR1: p21].

There were no specified rules for reaching recommendations in the original order. Therefore, at their first meeting in January 1988, the members themselves initially raised the issues they felt were important and "shared their vision" of preferred future health. They concluded that they needed to define and publish an initial mission statement and set of principles for health, in order to solicit reaction [PCRR1: p13]. That is, later information was structured into their final vision of future health care by way of the original draft mission statement and principles [PC189]. "As we listened to Albertans and read what they had to offer... as we reflected upon the views and meshed their thoughts with our own..." [PCRR1: p20]. This information implementation method is the way the commissioners reached their final recommendations.

The Commission was called by the Premier via an order signed by the Lieutenant Governor and it had to submit any interim or final report to him [GAI: p121]. This power was further illustrated in February 1988, when the Premier directed the Commission to specifically address nursing concerns focusing on a different set of references and involving different specified groups. This interim report was submitted to him in June 1988 [PCRR1: p14]. The activities of the Commission were financed by the government with grants set by Cabinet [GAI: p121]. The commission then was established and financed by a executive arm of the government and not an administrative arm.

Records such as meeting minutes, were to restricted to internal distribution while citizen participation was sought "through public meetings and written submissions" [GAI: p124]. Comments were sought through various means ranging from townhall meetings, to advertisements placed in newspapers and on radio, to having a toll-free telephone number and to having the members participate in interviews and talk shows as well as listening to their personal contacts and meeting with government officials, in addition to their touring of facilities and attending seminars and conferences. [PCRR1: p14]. The commission was said to generate a lot of interest [PC289]. Further input was sought by the commissioners themselves from provincial, national and international reports, studies and surveys which were read and the opinions of relevant experts who were consulted [PC188]. The mission statement, principles and essentials that were thought to represent the philosophy and major values which must underlie the future health care system then, were the result of input from discussion among the commissioners, internal research and public input [PCRR3: p6].

With regard to groups relevant to this thesis, the Alberta Medical Association (A.M.A.) recommended to the Commission that an independent agency, the Alberta Health Services Commission, should be set up to handle the planning, administrating and funding of health care since limited health care resources required that priorities be established. And health priorities must not be based on political priorities [PC289: p41]. The A.M.A. submission also suggested that while the agency would be directly responsible to the Minister of Hospitals and Medical Care, it would operate independently in order to escape priorities "influenced by political consideration" [PC289: p42]. Further, the proposed commission would have an advisory agency, the Health Care Options Panel, composed of government officials, physicians, and patients which would make recommendations to it on different aspects of health care delivery [PC289: p43]. The jurisdiction of the proposed Commission and Panel would include questions of technology, preventive medicine, ethical and legal issues as well as of alternative health care providers [PC289: p41]. The Panel's first priority would be to define the basic elements of health care which would be automatically funded by government. The first priority of the proposed Commission would be to revise the methods of hospital funding in order to establish a system of cost accounting and efficiency. Finally, it was thought necessary to encourage the patient to take more responsibility over their own health by leading healthful lifestyles [PC289: p43].

Specifically, the A.M.A. rejected the notion that alternative health care providers could provide health care services at less cost. Rather, it supported the idea that primary care physicians could provide these services more efficiently if the services of paramedical providers such as physiotherapists were established (and presumably funded) within physician offices. The submission rejected the notion that there is an oversupply of physicians and that restricting physician billing numbers would curb cost; it supported the idea that patient behaviour and expectations were the main factor responsible for health care costs [PC289: p42]. Many of these recommendations were echoed by the College of Physicians and Surgeons in that: government should decentralize its planning and administration of services, government must establish a formal policy advisory body on health care, primary care physicians should affiliate with community based disciplines forming a health care team, community projects must include home care, long term care and active treatment facilities and finally, policy should stress individual responsibility for health and the use of health care resources [PC289: p62].

Meanwhile, submissions by the organizations of physical therapy propose to educate the public to be responsible for their own well-being and feel that prevention would decrease costs. However, they further argue that there will be an increase of chronically ill and aged patients who will require self-care education and counselling. And they feel that physical therapists should play a more important role in this consultation both in institutions and private homes

[PC289: p61]. Whereas, the Health Services Association which represents both physical therapists and respiratory therapists, propose a multi-disciplinary approach to health care but would like to see health care employees receiving more recognition, among other things. They would like to see the establishment of a global ministry of health, less political involvement in the planning and administration of the health care system and more participation by employees and the public [PC289: p71].

Given the fact that the commission could address any problem in any way, it is not surprisingly that the title of the final report was **The Rainbow Report:** ***Our Vision*** **of the Future** [my emphasis]. There are however, significant differences found with their vision of change as stated in the recommendations that relate either to the governing and the administering of the health system itself, or to the health care occupations. Recommendations of governing and administering control, propose significant change in specific terms. The discussion of these recommendations includes statements that focus directly on the department involved and specify formal implementation. And following Alford (1975) it is presumed that the vague terms used in the recommendations of the report relating to health care occupations, would only reinforce the status quo and that the fuzzy rhetorical discussion surrounding these recommendations, would imply only informal implementation.

These differences can be seen in the respective section titles: "Planning and Power: **Serious Redistribution**" [PCRR2: p110] and "Health Care Providers: **Heartbeat of the System**" [PCRR2: p144] [my emphasis]. The commissioners themselves conclude that they have recommended "major changes" of the system but can only "anticipate a resolution of conflict" between paramedicals [PCRR2: p154]. Terms within the recommendations of the system would establish a new official, an Advocate who would operate at "arms-length" from the government and would review the system with regard to its "effectiveness, efficiency and suitability" [PCRR1: p38]. In addition, he would oversee the long range planning of the system to assist the government health department with the advice of another new administrative body, the regional Health Authorities [PCRR1: p39]. That is, the Advocate would not actually carry out the "planning, policy options analysis, measurements and evaluation" but would ensure that they are done by some other agency and would even collect its own data if the agencies involved would not cooperate [PCRR2: p115].

The second major change would be the establishment of regional Health Authorities. The province would be divided into nine autonomous administrative regions headed by a board of locally elected trustees and having an executive director who would be appointed jointly by the Health Authorities and the Department of Health. He would report to the Authority and a department official while the Authority itself, would report annually to the department [PCRR1: p40] with regard to the resource utilization, program and service fiscal arrangements and health status within its jurisdiction. It would manage the health system within its region [PCRR2: p121] and would not only have administrative funding control but also governing or executive control [PCRR2: p117].

In both cases, legislation would be required to implement these changes [PCRR2: p111, 120]. Statements within the report specifically attack the current government department of health. For instance, its priorities are said to be in need of reassessment [PCRR2: p110]; it is currently unable to long term plan given the complex area and the current administrative structure [PCRR2: p111]; and furthermore, the commissioners feel that it is time for the government itself to rethink its role in the administration of the health system [PCRR2: p117]. According to this argument, the establishment of Health Authorities would require that the role of the government administrative department would need jurisdictional reorganization and resource reallocation. [PCRR2: p121].

The discussion surrounding the recommendations on health care occupations is much more fuzzy. While the report does acknowledge that there is conflict between the occupations, it does nothing to address the conflict except to use vague emotive terms which invariably allude to the ideal of cooperative, complimentary and interdependent teamwork [PCRR2: p144,145] whose members would be operating within a level playing field [PCRR2: p144]. Furthermore, it is asserted that the occupations must avoid conflict as it may be viewed by the public as if occupations were acting in self-interest, a view which is not only contrary to their professional ethics but may undermine public trust in them [PCRR2: p94]. The solution proposed is to established a climate that would manage or minimize the conflicts [PCRR2: p147]. And this climate would be accomplished not by new specific legislation, but by the distribution and discussion of the commission's vision statement in order to promote common understanding followed by acceptance and finally, commitment to their current roles [PCRR2: p146].

The recommendations themselves then, do not propose change but in fact, reinforce the status quo at all levels [PCRR1: p45]. The terms of how this is to be accomplished are also quite vague. That is; meritorious and outstanding service should be rewarded, somehow and the members should be involved in decision making, somewhere. The work institutions should make more effort to reduce conflict between health occupations and to encourage cooperative teamwork, in some way [PCRR1: p44]. Courses should be developed within educational and health care institutions to emphasize the complimentary nature of the occupations and to deal with stress management in order to help the worker understand this relationship and to build tolerant health care teams. Furthermore, ethic courses should be developed to deal with these issues and should be taught to all students [PCRR1: p45].

Given the wide jurisdiction of the commissioners' mandate then, there are different types of change recommended depending of the area addressed. With regard to the governing and administration of the system, significant deep structural change is specifically proposed by way of formal legislative means, for deliberate reasons. With regard to health care occupations, no real change is advocated. The status quo is to be reinforced by vague means and justified by the fuzzy rhetoric of tolerant health care teams.

The report was formally presented to the premier by the commission chairman after two years duration and at a $4.2 million cost [PCRR3: p37]. The public could obtain a limited number of printed copies and videotapes from the Queen's Printer for $30 while copies of the video may be borrowed from the Provincial Film Library [PCRR1: p70]. Copies of the newsletters were widely distributed [PCRR3: p37]. Furthermore, the research data base should be available for individual projects at the Alberta Health department library [PCRR3: p36].

C. GOVERNING RIGHTS

Generally speaking, a by-law, ministerial order, regulation or act is not implemented in the same way nor necessarily by the same governing body. And it may not be specifically sanctioned in the same way. The differences in these types of governing rights can be noted in the preamble to the legislation. The preamble of an Act will state:"**HER MAJESTY**, by and with the advice and consent of the Legislative Assembly of Alberta enacts as follows:... [IA: s11]. The Legislature is defined as: "The Lieutenant Governor acting with the advice and consent of the Legislative Assembly of Alberta" [IA: s25(k.1)]. A regulation which usually must be passed by the Lieutenant-Governor-in-Council, will have the preamble: "Upon the recommendation of the Honorable Dr. Reid, the Lieutenant Governor in Council, pursuant to section 73(2)(b) of the **Physical Therapy Profession Act**, approves the regulation of the attached Appendix, being the General Regulation" and it is signed by Peter Lougheed (Chairman) [PTR: p1] or "Upon the recommendation of the Honorable Dr. Reid, the Lieutenant Governor in Council pursuant to section 27 of the **Health Disciplines Act**, approves the regulation in the attached Appendix, being the Respiratory Technologists Regulation" and it is signed by Peter Lougheed (Chairman) [RTR: p1]. The Lieutenant-Governor-in-Council is defined as: "The

Lieutenant Governor acting by and with the advice of, or by and with this advice and consent of, or in conjunction with the Executive Council" [IA: s25(1.1)].

The interaction between the terms of Regulations and of Acts is important to occupational control in that terms within the Act may authorize a Minister to take some action (a) in the name of his office or (b) by the deputy minister of that office, although the deputy cannot pass regulations under the authority given to the Minister [IA: s21(1)]. Furthermore, if an Act confers the right to make a regulation, it also confers the right to repeal or to amend the regulation and make a different one [IA: s23(4)]. And most importantly, if the terms of an Act are changed, all regulations that come under the terms of the Act remain in place but with reference to the new terms of the Act [IA: s32(e)].

(b1) indirectly: by the legislature

The Legislative Assembly is one of the three arms of government seen to exist under the Lieutenant Governor. The other two are the Executive Council including the Premier and the Judiciary including judges [GAO: p2]. It is the Legislative Assembly that has governing rights to ultimately prescribe and to pass terms of the Acts which in turn, may grant governing rights to the other bodies including those within the health care system [AA: s10]. The Legislature in Alberta consists of the Lieutenant Governor and one house, the Legislative Assembly [AA: s12] which is composed of members elected from electoral divisions within the province [LAA: s2]. A person becomes a member upon being elected [LAA: s1(2)] and upon taking an oath of allegiance [LAA: s1(3)].

The jurisdiction of responsibility of this provincial body include the provision of health care to its citizens [BNA: s92(7)], among other things. Proposed actions addressed in this house are passed by a majority vote [BNA: s49; AA: s3]. When a bill is passed by the Assembly and has received the assent of the Lieutenant Governor, the Clerk of the Assembly will endorse the official copy and the date of its ascension [LAA: s7(1)] and shall provide a "certified copy of the official copy" to anyone who requests one and pays the prescribed fee [LAA: s7(7)]. Furthermore, a member of the Executive Council who heads a government department must prepare an annual report for the Assembly each year summarizing the activities of the department [LAA: s52].

(b1) indirectly: by the lieutenant-governor-in-council

The Lieutenant Governor in Council is composed of the Executive Council now the Cabinet, and the Lieutenant Governor [BNA: s66]. Formally, the Executive Council is said to be composed of persons the Lieutenant Governor appoints as he "thinks fit" [AA: s8] [BNA: s63].

Regulations are usually either initiated by a body such as the P.T. Council and passed by the Lieutenant Governor in

Council [IA: s23(5)(b)] or prescribed by the Cabinet and then proclaimed by the Lieutenant Governor [IA: s25(1)(1.1)].

These types of governing rights are fully illustrated in the occupational Acts of the two paramedicals studied. The Lieutenant-Governor-in-Council appoints the members of the Health Disciplines Board [HDA: s3(1)], may approve [HDA: s27(2)], vary and then approve, or disapprove regulations initiated by the Board [HDA: s27(3)(a),(b),&(c)]. And it may pass, amend and pass, or repeal a regulation proposed by the Minister [HDA: s28]. The Lieutenant-Governor-in-Council has fewer and more indirect rights with regard to the P.T.s in that it may only approve regulations [PTA: s73(2)(b)] initiated by the P.T.Council [PTA: s73(1)] and passed by a majority of their own members [PTA: s73(2)(a)].

These types of enabling legislation are also found in the Acts of the two departments whose jurisdictions encompass most of the health care system, the **Department of Hospitals and Medical Care Act** and the **Department of Community of Community and Occupational Health Act**. For example, within the Department of Community and Occupational Health and the Department of Hospitals and Medical Care, the Minister may make funding grants if it states that he can do so in the regulations [COA: s9(1)(a); HMA: s7(1)(a)]. But it is the Lieutenant-Governor-in-Council that initiates and passes the regulations in the first place [COA: s9(2) & HMA:

s7(2)]. Furthermore, many of the actions of the Minister are subject to the approval of the Lieutenant-Governor-in-Council [COA: s11(2) & HMA: s7.2].

Under the **Hospitals Act**, the Lieutenant-Governor-in-Council may pass regulations determining the standards of services to be maintained by "approved" hospitals [HA: s44(1)(b)]. But the Minister "by order" has the right to determine which hospitals meet those standards [HA: s44(2)(a)] and may suspend funding to those that do not meet them [HA: s52].

Moreover, the Lieutenant-Governor-in-Council will establish a Health Care Insurance Fund [HIA: s31(1)] which the Minister holds and administers [HIA: s31(2)]. Out of this fund will come the monies necessary to cover the cost of programs [HIA: s31(4)] authorized by the Lieutenant-Governor-in-Council [HIA: s30(e.2)]. It may also prescribe the establishment, power and duties of specific committees concerned with the terms and administration of the Alberta Health Care Insurance Fund [HIA: s30(6)] and more generally, may pass regulations on any matter considered necessary for its administration and operation [HIA: s30(f)].

With regard to practitioners providing the services, the Lieutenant-Governor-in-Council may make and pass regulations on any matter concerning the entitlement of benefits [HIA: s6(e)(iv)]. It may require that the practitioner provide certain information prescribed in the regulations to the Minister [HIA: s6(j)] and may authorize the Minister to withhold payments for these benefits [HIA: s6(k)] in order to enforce compliance with these regulations. And, the Lieutenant-Governor-in Council may stipulate by regulation, what type of recoverable payment (income structure) may be made from the government insurance fund [HIA: s30(e.1)].

With regard to services, the Lieutenant-Governor-in-Council designates which "classes" of goods and services are to be "basic" or "extended" [HIA: s6(b)] or "optional" [HIA: s27(b) while the Minister specifies which goods and services will be included within the classes of "basic", "extended" [HIA: s7(c)] or "optional" services [HIA: s29(b)]. The Lieutenant-Governor-in Council designates which "basic" services are to be insured by the government [HIA: s2] and the Minister prescribes the rate of benefits payable for "basic" or "extended" services [HIA: s7(a)]. The Minister also sets the rates and the amount of money to be paid for the "optional" services [HIA: s29(a)] within those classes prescribed by the Lieutenant-Governor-in-Council [HIA: s29(b)].

With regard to non-government insurance, the Lieutenant-Governor-in-Council retains the right to pass regulations on any matter it considers necessary for the administration and operation of the **Alberta Health Care Insurance Act** [HIA: s27(h)] as it relates to optional health services [HIA: s27(b)]. More specifically, it defines the powers and duties of the carrier covering these optional services [HIA: s27(g)(iii)], the fees to be paid to the carrier [HIA: s27(g)(ii)] and any other matter concerning the terms of the contract and its administration [HIA: s27(g)(iv)]

Section 75 of the **Public Health Act** outlines the power of the Lieutenant-Governor-in-Council to pass regulations concerning among other things, the functions and duties of the local board [PHA: s75(j.1)], the services, supplies and equipment that must be provided [PHA: s75(p)] and those services, supplies and equipment that may be provided [PHA: s75(p.1)]. It also makes regulations authorizing the local board to charge fees for the goods and services and the amount to be charged for them [PHA: s75(p.2)].

Generally speaking, the terms of the governing rights of the Lieutenant-Governor-in-Council are more encompassing than the terms establishing Ministerial orders and occupational by-laws and often will state within the section labelled "regulations" that it has the ultimate right to pass regulations on any matters "necessary to carry out the purposes and objects" of the legislation in question [HIA: s27(h) & HA: s62(L)].

(b2) indirectly: by ministerial order

The Minister is usually defined as: "... the member of the Executive Council charged by the Lieutenant Governor in

Council with the administration of an Act [RA: s1(c)] or a department [HMA: s2; COA: s.2]. His governing rights are also stipulated in terms of enabling legislation.

A specific minister is charged with the administration of the **Health Disciplines Act** [HDA: s1(e)]. This minister may establish advisory committees to the Board [HDA: s4.01(1)] and appoint the members of the committees [HDA: s4.01(2)]. He may specify that the health care occupations coming under the Act be governed by a Committee [HDA: s4.2(a)] or Association [HDA: s4.2(b)]. This process led to the establishment the R.T. Committee, in this case [HDA: s5(1)(a)] and to the appointment of its members [HDA: s5(2)]. More importantly, this Minister may direct the Board to investigate the possibility of placing a paramedical occupation under the Act in the first place [HDA: s4(1)(b)] and may request the Board to make, amend or appeal a regulation or he may overrule Board actions by going directly to the Lieutenant-Governor-in-Council to have a requested regulation passed [HDA: s28].

With regard to P.T., a different Minister in charge of the Department of Hospitals and Medical Care appoints the nominated public member to their Council [PTA: s10(b)]. The Department of Hospitals and Medical Care for which he is responsible, must be notified of registration suspension and reinstatement decisions of members made by the various bodies of the College or the Courts [PTA: s30(a)&(b)] and an

Annual Report of the P.T. College activities must be submitted to him [PTA: s9(3)].

Furthermore, the Minister of the Department of Hospitals and Medical Care, as found within terms of Part I:Organization of General and Auxiliary Hospital Districts of the Hospitals Act, may initiate the first hospital programs within a hospital district [HA: s5(1)] which shall contain any item of operation or finance that the Minister decides as well as, matters relating to construction, equipment, furnishing and the utilization of services and facilities of adjacent facilities [HA: s5(1)(d)]. The Minister may submit this program to the municipal councils concerned for approval [HA: s6(1)]. When it comes to financing this program, the municipal council may be asked to help, but the Minister decides the proportion it will pay [HA: s18(4)] and his decision cannot be challenged by the courts [HA: s18(5)]

Within hospitals, the Minister may, after consultation with medical, nursing and pharmaceutical associations, prescribe model general by-laws to guide the board [HA: s37(1)(a)] and model medical by-laws to guide physicians [HA: s37(1)(b)] which he then may designate as applicable to all approved hospitals [HA: s37(2)]. Not surprisingly, the Minister may then withdraw approval of any hospital or medical by-laws. [HA: s37(4)]. He may also determine which hospital offers a standard of services that qualifies that hospital to be designated as "approved" [HA: s44(2)(a)] and may suspend or adjust any grants or payments to a hospital board that does not comply with the Act or Regulations [HA: s52]. The Minister may dismiss the hospital boards "for cause" and appoint an administrator instead [HA: s25(1)].

In each fiscal year, the approved hospital will submit to the Minister, a prospective budget covering the predicted expenditures of providing hospital and related health care services which the Minister will then review in order to determine general operating grants and specific program grants [HBR: s12(5)]. The Minister may increase or decrease the amounts of these grants [HBR: s12(6)] while any funding deficit becomes the responsibility of the hospital board [HBR: s12(7)].

In order to provide advice regarding these decisions, a Health Facilities Review Committee is established by its own Act, consisting of twelve members appointed by the Minister [HFCA: s2(1)], for terms prescribed by him and a chair designated by him [HFCA: s2(3)].

From funding rights stipulated in the **Health Care Insurance Act**, this Minister may also prescribe the rates of benefits to be paid for "basic" and "extended" services [HIA: s7(a)]. He may also define the manner in which these benefits will be paid such as to whom and under what conditions, as well as the specific information required for payment [HIA: s7(b)]. All individual claims for benefits are subject to Ministerial approval [HIA: s4(2)]. In reassessing the claim, the Minister may decide whether this particular service is given too frequently [HIA: s8(2)(a)], whether the amount of funding claimed is correct [HIA: s8(2)(b)] and even more specifically, whether the service given was appropriate [HIA: s8(2)(c)] or whether a similar service could have been provided at a lower rate by another type of practitioner [HIA: s8(2)(d)].

However when passing judgement on the actions of an individual practitioner, the Minister must take into account the recommendations of a committee appointed by the involved association's own board [HIA: s8(4)(h)(i)], members of that association [HIA: s8(4)(h)(ii)] or any other committee that is recognized by the Minister [HIA: s8(4)(h)(ii)]. The Minister then may among other things, make appropriate adjustments of benefits [HIA: s8(5)] or withhold benefits [HIA: s8(7)] but must notify the practitioner of the reassessment so that he may appeal to the Courts [HIA: s8(8)].

Within the **Alberta Health Care Insurance Regulations**, funding is structured due to terms which define physical therapy services as those listed in the **Physical Therapy Benefits Regulations** [HIR: s1(k)(i)(a)] and further terms specified in Sections 11 and 35 of the **Alberta Health Care Insurance Act** [HIR: s1(k)(i)(B)]. Specifically, the terms in HIA Section 11 allow the Minister to pay for these services on the basis of an income structure other than fee-for-service. While the terms in Subsection HIA 35(1) allow the Minister to enter into and implement a special agreement with (a) any government person or any unincorporated group needed to administration the plan and (b) concerning any other necessary matter not covered in the current act and regulation.

The Alberta Hospital Association in its administration of the Blue Cross plan which funds some health care services, enters into an agreement with the Minister but this agreement and its terms are "subject to approval by the Lieutenant-Governor-in-Council" [HIA: s37(1)]. The terms include among other things, the goods and services to be provided under the agreement [HIA: s37(1)(c)] and payment by the Minister to the A.H.A. for them [HIA: s37(1)(b)]. Furthermore, this agreement may contain any other terms that are felt to be necessary for the provision of these services and their funding [HIA: s37(1)(d)]. And again, the Lieutenant-Governor-in-Council may pass regulations on any matter included within this agreement between the Minister and the Alberta Hospital Association [HIA: s37(4)]. The Minister holds and administers the Alberta Health Care Insurance Fund [HIA: s31(2)], out of which must be paid the monies to the Alberta Hospital Association that are necessary for the administration of this insurance plan, under the Blue Cross agreement [HIA: s31(4)(6)]

In 1988, the responsibilities stipulated in the **Public Health Act** fell to yet another Minister, the Minister of Community and Occupational Health [PHA: s1(p)]. In administering these duties, the Minister may delegate these powers, responsibilities and functions to the local board except the power to "regulate" [PHA: s23(1)] but may also dismiss the local board "for cause" [PHA: s24(1)]. This Minister pays grants to these boards in the amount and manner he considers appropriate [PHA: s26(2)], as does the Minister responsible for hospitals. And the Minister may enter into an agreement with any person or association for the purposes of carrying the Act [PHA: s25(b)]. As in the case of the hospitals, the board is responsible to the Minister who has the ultimate responsibility for ensuring that the services stipulated in the regulations are provided to the residents of Alberta [PHA: s22(1)] and for deciding if the prescribed services will be provided to an individual not covered either under the **Alberta Health Care Insurance Act** or the **Hospitals Act** [PHA: s22(2)].

The department acts themselves, also contain terms regarding the supply of occupational services. Examples of this type of governing rights are well illustrated in the terms of the very important **Department of Hospitals and Medical Care Act** and the **Department of Community and Occupational Health Act**. Section 2 of both Acts establish the respective departments as those to be administered by a

Minister or member of the Executive Council. Sections 4 to the end of the respective Acts establish what the Minister may do. These rights range from establishing advisory bodies [HMA: s5; COA: s7] to making grants for payments [HMA: s7; & COA: s9] if he is authorized to do so, in the accompanying departmental Regulations [HMA: s7(1)(a); & COA: s(9)(1)(a)] which the Lieutenant-Governor-in-Council may pass [HMA: s7(2); & COA: s(9)(2)].

(b2) directly: by occupational by-law

Various terms of enabling legislation are also found within the respective occupational Acts which grant governing rights to the occupations. That is, the enabling terms allow an occupationally controlled body to pass by-laws on various activities. Neither of these occupation's by-laws are to be considered regulations in that they do not have to be passed by the Lieutenant-Governor-in-Council to become effective [PTA: s74(3); & HDA: s5(10)].

With respect to Respiratory Therapy, the jurisdiction within which the member dominated, R.T. Committee in a Committee/Board relationship, may pass its own by-laws or rules as they call them, is limited to such activities as to when and where the Committee will meet and other matters pertaining to administrative Committee business [HDA: s5(10)]. This Committee must have a majority of its members from R.T. [HDA: s5(2.1)].

Furthermore, for R.T. members, there is no term within the **Health Disciplines Act** that states that these paramedical members must obey the occupational by-laws or face occupational sanctions. In fact, there are no effective sanctions because being an R.T. member is not a necessary condition for employment in their important work domains [HDA: s2(3)].

The situation with respect to the governing rights of Physical Therapy is very different. The jurisdiction in which the member dominated, P.T. Council may pass by-laws was detailed earlier. For instance, it may pass by-laws on the management of its own meetings [PTA: s74(c)] the voting procedures within the College [PTA: s74(t)] and the election of the members of the P.T. Council and officers [PTA: s74(d)]; the establishment of classes of membership in the College and the respective privileges and obligations for each [PTA: s74(h)]; the procedures to be followed by the Registrar to remove specific entry details from the Register [PTA: s74(o)] and the publishing of register applicants names [PTA: s74(p)], in addition to the nomination of the public member that the Minister may then appoint to the Council [PTA: s74(e)] and the appointment of members to its mandated Discipline Committee and Practice Review Board [PTA: s74(f)]. It may also pass its own by-laws governing the registration of P.T. Corporations and its rules of ownership [PTA: s74(w)] and most significantly, governing the designation of accredited clinical facilities [PTA:

s74(x)]. The composition of the Council prescribing these by-laws is of at least eight elected members of the P.T. College and one Ministerial appointed member [PTA: s10(1)(a)&(b)].

P.T. members must follow the terms **Physical Therapy Profession Act** or regulations [PTA: s37(1)] or they will be charged with professional misconduct. In addition: "If an investigated person contravenes this Act, the regulations or the by-laws" which the Discipline Committee feels is serious [PTA: s37(2)], he will be charged further. And from the Act, terms specify that if the P.T. is charged with professional misconduct, the Discipline Committee may in the extreme, cancel the registration of that member [PTA: s54(j)] or corporation [PTA: s54(k)]. Other terms of their Act state that their members are the only ones permitted to provide physical therapy services [PTA: s3(1)] and that an accredited facility for P.T.s is :" a clinical facility designated in the by-laws as an accredited facility" [PTA: 6s1(a)].

CHAPTER VIII: DISCUSSION

A. INTRODUCTION

Using the framework as the organizing vehicle, Chapters VI and VII detailed the formal privileges on sixteen dimensions which have been granted to Physical Therapy and Respiratory Therapy. The restrictions are also summarized. This material was presented without interpretation or explicit comparison. In this chapter conclusions and interpretations are drawn. These focus on the different forms and degree of occupational control of each group and on the power relations found among each paramedical occupation, medicine and the state. The form and degree of occupational control is viewed along the several dimensions as a legal configuration of privileges.

There are different ways of being granted formal occupational control and power. That is, within the various types of legislation, specific terms state either the occupation's privileges directly or they establish an occupational body or government agency. The body or agency is then granted administering or governing rights through enabling terms. The means of implementing the terms then varies and can be carried out by different government agencies or occupational bodies. Generally, terms within an act are implemented by way of the Legislature, regulations by way of the Lieutenant-Governor-in-Council and bylaws by way of the occupation's own corporate body.

Occupational control is discussed following the framework, on the dimensions that encompass different aspects of the occupation's activities. These activities are generally divided into two areas; its membership and services. The control of these activities is seen as occurring within two contexts, the health division of labour and the broader institutional framework. The other groups involved in different ways and to different degrees are medicine and state.

It will be concluded that paramedical occupations do have some occupational control of their activities. It will be shown that P.T. has been granted a form or configuration of legal privileges that gives it more control of its members and services than the one granted to R.T.. Related to this control, it will also be shown that in its relationships to other groups, P.T. has a pattern of power that places it in a stronger position within both contexts or arenas, than the position of R.T.. These legal foundation of these relationships is found within the terms that set up other agencies or bodies and from the enabling terms that grant further rights to these agencies and bodies. Finally, it will be shown that the differences in occupational control and in power relations interact and are reflected in an occupational monopoly pattern that even more extensively differentiates the control these occupations have obtained of the membership and supply of services.

B. FORMS OF OCCUPATIONAL CONTROL

This discussion follows the information summarized in Table 1 and Table 2 found on the following pages. The reader should refer to these tables for further clarity.

The granting of an exclusive title backed by government, serves as a signal not only to the public, but to the government as to which occupational members may receive further legal privileges and restrictions. Both R.T. and P.T. have exclusive right to new titles. P.T. has supplemental membership titles and corporate names sanctioned as well. But since P.T. has not secured the exclusive right to the old title, they have not prevented other practitioners from practising in the health care marketplace under the title 'physiotherapy'. These practitioners probably would not receive further legal privileges granted to Physical Therapy but they would also not have to follow the legal restrictions of the newly titled P.T. members. Therefore, P.T. has less control of the restriction of its membership than R.T. on this dimension since it did not secure the exclusive right to its former title.

Table 1 summarizes the different forms of occupational control held by Respiratory Therapy and Physical Therapy of the marketplace within which they provide their services. The rows in the table follow the dimensions of the theoretical framework found in Figure 5.

Table 1

SUMMARY OF FORMAL OCCUPATIONAL CONTROL OF THE ECONOMIC MARKETPLACE: PHYSICAL THERAPY AND RESPIRATORY THERAPY

I. MARKET CONTROL	**PHYSICAL THERAPY**	**RESPIRATORY THERAPY**
A. OF MEMBERSHIP		
(a1) Right to Title.	Non-exclusive	Exclusive
(a2) Occupational Credentials	More Stringent	Less Stringent
(a3) Code of Ethics	Competition	Co-operation
B. OF SERVICES		
(b1) Scope of Practice	Delimited, Permanent and Vague Boundaries	Restrictive Changeable and Specific
(b2) Gatekeeping Rights	Medical Referral Only	Medical Referral and Supervision
(b3) Domain of Work	Essential in Hospital/Legal Private Practice	Non-Essential in Hospital/Home Care Program Option
(b4) Income Structure	Salary & Fee-For-Service	Salary & Contract

Table 2

SUMMARY OF FORMAL OCCUPATIONAL CONTROL OF THE POLITICAL MARKETPLACE: PHYSICAL THERAPY AND RESPIRATORY THERAPY

II. POLITICAL CONTROL	**PHYSICAL THERAPY**	**RESPIRATORY THERAPY**
A. ADMINISTRATIVE AUTHORITY		
(a1) Register Management	Self-Regulating	Advisory
(a2) Register Administration	Self-Regulating	Limit Self-Regulating
(a3) Government Responsibility	Non-Participating	Non-Participating
(a4) Government Co-ordination	Non-Participating	Non-Participating
(a5) Government Change	Submissions	Submissions
B. GOVERNING AUTHORITY		
(b1) Indirect	Non-Influential	Non-Influential
(b2) Direct	By-Laws with General Application	By-Laws with Limited Application

Table 2 summarizes the different forms of control held by Physical Therapy and Respiratory Therapy in the political arena within which agencies and bodies of the institutional framework, function. This table indicates any control the occupations may have of them. The rows refer to the Level II dimensions of the theoretical framework: Figure 5

From the terms of their respective occupational legislation, one can see that both R.T. members and P.T. members must meet the usual character, educational and fee requirements for initial member registration and its renewal. This is also true for registration of P.T.s private practices. There are interesting differences between the two occupations on the specified requirements such as a greater number and different character requirements, higher academic requirements and more stringent clinical requirements for P.T. members. P.T. has supplemental membership titles and corporate names sanctioned as well. Therefore, on the matter of credentials, P.T. has more control of its membership than R.T.

With respect to the ethical code, legislative terms for both occupations state concern for the patient. And there are general ethical statements regarding violations of all terms within their various forms of occupational legislation which effectively reinforce any terms found within their act, regulations and by-laws. Other terms differ with regard to interoccupational and intraoccupational competition. For P.T., the emphasis is on providing service 'by referral' while for R.T., the emphasis is to promote co-operation with all health personnel. Within private practices, there are many terms controlling competitive behaviour between P.T. private practices similar to those described in the literature on the medical profession. Furthermore, only registered P.T. members may work in occupationally registered private practices. For these reasons, P.T. has been granted more control of its membership than R.T. on this dimension as well.

Overall, specific terms within their respective occupational legislation grant members of both occupations certain rights and responsibilities. P.T. registered members having more rights and more responsibilities (requirements), than R.T. registered members. The control of its membership is but one aspect of the occupational activities; control of the supply of its services is the other.

Occupational control of its activities also differs between P.T. and R.T. as it relates to the supply of its services in the health care division of labour. With regard to their respective scopes, R.T. has a more restricted and specified scope than P.T. but it does include some interesting new aspects of occupational control such as equipment maintenance and research. Furthermore, P.T. has more control than R.T. since its terms are more permanent. Also its terms of scope are more vaguely defined: this allows for the incorporation of new services without a change in legislation.

Both R.T. and P.T. have medical gatekeeping restrictions placed on their services but there are differences in degree and form. While both paramedical occupations provide their services under medicine's broad scope of legitimized services, P.T. has been granted greater occupation control of its own services. That is, P.T. members are allowed to further diagnose, treat and evaluate their services within the vague definitional scope, subsequent to a referral from the physician. This pattern is more typical of a physician specialist and unlike the one forecast in the literature on paramedicals. R.T. has its supervised by physicians after the medical referral.

But in order to achieve significant control, an occupation must provide its membership employment opportunities within different domains especially in domains where the physical plant, equipment and supplies are reliably funded by a third party. To achieve this control, its services must be designated as essential and its members must be designated as the only providers allowed to perform them.

The complexity then, of the control of these paramedical occupations in the delivery of their services is such that while their scope and gate-keeping control may structure them within the medically defined marketplace, the government established domains of work and income structure may either reinforce or negate this control. This differing control is illustrated in the different funding stipulations of P.T. and R.T. fulfilment of health care requirements within different domains. P.T. is granted more control within hospitals, R.T. more control within a health care program and P.T. more control within formal private practices.

P.T. services are formally required within all domains which are largely funded by government in some form and their registered members must provide these services. R.T. may have achieved some unusual control by being permitted by medicine, and possibly hired by government, to provide their occupational services to fulfil home care program commitments. Otherwise, theirs is a very limited pattern of service delivery defined by restricted scope and extensive gate-keeping restrictions. In addition, their services are not specified as "essential" in the required domains where they work and if specified, the employer may hire someone other than a registered R.T. member, to perform them.

Furthermore, R.T. has no formal control of the structure of their income since it does not control the sources of funding nor the type of income in any of their work domains. P.T. has achieved a great deal of control over the structure of income in private practice since terms in the **Physical Therapy Benefits Regulations** grant it separate government funding of their members' specific services, as opposed to physician specialists' services, on a modified fee-for-service basis. Yet, these particular services funded by fee-for-service are restricted to those given within a private practice office. The fee-for-service schedule does not extend to services given within a private home or government funded institution.

As was shown in the summary above and in Table 1, P.T. and R.T. have secured different terms of operation within the economic marketplace. On this basis, P.T. has more occupational control of its activities than R.T..

But specific terms within their respective legislation may also establish government agencies and occupational bodies with enabling terms which may grant them certain rights. In this context, three agencies/bodies were established by the respective occupational legislation; two occupational bodies (the R.T. Committee and the P.T. Council), and one government agency (the Health Disciplines Board). Furthermore, it has been assumed in the literature that an occupational body with important control may initiate the terms of the legislation that it would like the government to legislate. Therefore, if an occupational body has the right to initiate the terms on the previous dimensions, it has reinforced its control. Its control will not be reinforced if a government agency has the right to initiate the terms on the dimensions contained in Level I of the framework.

The Health Disciplines Board has the right to initiate the terms of the R.T. title thereby reducing R.T. control on this dimension. But more importantly, once having obtained a legal exclusive right to title, it then becomes essential to the occupation's control to be able to determine the necessary requirements that a prospective practitioner must meet to become a registered member. To have an exclusive title but not to be able to specify the occupational credentials required to qualify to use it, does not give the occupation control that is strong nor extensive.

The P.T. Council has more control in the definition of these terms than does the R.T. Committee. While many bodies have been established to initiate the terms of its occupational credentials, the P. T. Council retains control of these related bodies either directly or indirectly. The Council itself, has been given further control through enabling terms of its occupational legislation which allow it to initiate regulations or to set its own occupational by-laws over many aspects of its different occupational credentials. Hence, further implementation of important legally binding terms are by regulation or by-law. In this way, P.T. has reinforced its control of its occupational credentials.

For R.T., terms within the **Health Disciplines Act** require that a government administration agency, the Health Disciplines Board, be established. Through enabling terms within the Act, this Board has been granted the power to initiate regulations of the initial requirements and it must approve any occupational committee recommendations for renewal requirements. Therefore, most of the R.T. register requirement terms are found in their regulations. In this way any control that R.T. may have had with regard to its occupational credentials is lessened.

Again, with regard to the code of ethics, enabling terms within the respective acts grant the P.T. corporate body (Council) more control of its members than the R.T. corporate body (Committee). For R.T., this power is held by a government board. Therefore, not only are the terms covered by the ethical legislation different, many terms are located in different forms of legislation. That is, R.T. members must follow terms set more permanently in the **Health Disciplines Act** and also in their regulations. Whereas, for P.T., some terms are found in their Act however, a larger number of very important terms are located within their regulations and perhaps, their bylaws.

Therefore, the P.T. Council, through its control of various bodies and its right to initiate legislation, retains a pattern of much more control of the restriction of its membership than does the R.T. Committee. For R.T. this power is held by a government established and maintained Health Disciplines Board.

The fact that a government occupational bureau may initiate many of the terms related to R.T.'s activities with only advice given by its own body, is a pattern that is repeated with respect to the scope of practice and the gatekeeping rights of their services. P.T.s' Council has its pattern of privileges repeated on these dimensions. For instance, R.T. has all its more detailed and restrictive scope specified in regulations which a government board initiates, with only advice given by the occupational committee. P.T.'s scope is set in its occupational act. P.T.'s own Council has more control in setting the gatekeeping of its own services; R.T. limits are initiated by a government board.

With regard to the domain of work, the government establishes many other agencies and these will be more fully explored in the discussion on patterns of power. However, the influence of medicine is considerable in the delivery of paramedical services within each domain. It is constrained however, by the formal responsibility held by other agencies such as hospital boards. Government, through its funding directions and legislative control, has considerable power in defining the terms of service provision including the income structure.

In summary: The different control configurations were illustrated not only in the terms of the various types of legislation as they relate to the closure of its membership and control of the supply of its services, but in how the terms were implemented within various forms of legislation. Furthermore, the groups which held the power to initiate these terms also differed between the occupations with a P.T. occupationally controlled body retaining control of

P.T. activities while a government body, the Health Disciplines Board, held this power over R.T. activities.

The differences in these control configurations were repeated in the dimensions of register management and register administration (see Table 2). That is, Physical Therapy has control of the management of its register in that it either hires, appoints or elects members of the various bodies that operate in this area. Medicine does not have any direct legal power within this dimension. The government, however, does retain the right to appoint public members to some of the occupation's bodies. Government's power over R.T. on this dimension is much stronger in that it not only has the right to appoint members to all the bodies involved in managing the register; the bodies themselves are generally government administrative agencies. The activities of the agencies are formally defined in a legislative act and they are funded by government.

From the description of the register administration of the two paramedical occupations studied and based on selected sections of the act and regulations, one can see that P.T. has much more self-regulatory control than does R.T. Its own occupational bodies - the Registration Committee, Practice Review Board, Discipline Committee and Committee of Inquiry - pass judgement on the applications for registration, annual renewal, corporate permits, as well as the discipline and reinstatement of members.

Furthermore, the P.T. Council controls the appointment of the members of these bodies except for the public members appointed by the Minister and the possibility of physician appointments as "knowledgeable" members of the Discipline Committee.

For R.T., these activities were again primarily performed by the government hired, Registrar of the government established, Health Disciplines Board. It is this Registrar who must submit an Annual Report to the Minister. The government appointed, majority member, R.T. Committee has an expanded role in the administration of R.T. membership. Generally, not only does the R.T. Committee have only an advisory role to a government administrative board which has its own advisory appendages but these government agencies are themselves overseen and monitored directly by Cabinet. Physicians are legally placed in important mandated positions, are possibly placed in important administrative positions on the various types of government administrative agencies or may be placed as the 'knowledgeable' members of this Committee.

Therefore, R.T. has more control of its title than P.T. but this is negated by the fact that a government board initiates the proposed title. P.T. has more control than R.T. of its occupational credentials, both in its terms and by the fact that its occupational bodies initiate many of the requirements. This situation also applies to control of the code of ethics. P.T. has more control of its scope of practice primarily due to its terms but also due to the fact that for R.T., the terms of this important dimension are initiated by a government board with only advice given by the occupational body. P.T. has more control than R.T. on the gatekeeping rights vis a vis medicine, both due to its terms and to the fact that the government board also initiates these terms. With regard to domain of work, the initiation of these terms is done by government and while R.T. may have achieved more control in a home care program, P.T. has more control in hospitals and private practice. The greater control of P.T. especially in private practice, is reinforced by the difference in the income structure initiated by government. Finally, compared to R.T., P.T. has greater control both of its register management and register administration.

Furthermore, within both acts, it is stated that the terms of the act in question do not apply to other practitioners practising under the terms of another act. Therefore, we might expect that as more health occupations are legislated by the state, the health care division of labour will be more rigidly and specifically structured. Further, we might expect that the efforts of the groups wishing to establish occupational control will be occurring between the occupations and government rather than between each other or between themselves and medicine.

Traditionally, medicine's power over paramedicals has been informal and direct through such means as accrediting the paramedical's association and exams and influencing its supply of services by the accreditation of the health institutions in which they worked (Freidson 1970a; Larkin 1983). According to the findings of this study, the situation has now changed. Physician power may now be manifest formally but more indirectly, over paramedical members as well as the supply of services, through representation on various government agencies that administer and govern the entire health care system and not as much through membership on occupational bodies. It would be therefore, more powerful over R.T. through their possible placement on the Health Disciplines Board and on the expanding number of other related government agencies.

C. PATTERNS OF POWER

As detailed above and shown in Table 1 and Table 2, specific terms within various types of acts spell out important details of occupational control. They also establish government agencies and occupational bodies which are given administrative and governing rights within the enabling terms of the same acts. The discussion here will focus on the agencies and bodies involved, and the relationships between them as they are structured by terms of the acts.

The Health Disciplines Board directly oversees the activities of R.T. as well as other paramedical occupations covered by the Health Disciplines Act. It is a board with a specified complex jurisdiction but with a very limited, yet extensive occupational focus. That is, its functions include the investigation, regulation and monitoring of paramedical occupations. The Board's membership does not necessarily include any paramedical members yet it must have two physicians. Furthermore, the Board has complex relationships with other bodies such as different types of Ministerial appointed advisory bodies which also may have physician members. The Respiratory Therapy Committee may also advise this Board but physicians may be structurally embedded into every aspect of its complex jurisdictional structure.

Terms of the Act, stipulate the rights and responsibilities of the Board and final administrative power is given first to the Minister and then to Cabinet. R.T. does not have much influence over this Board. In fact, it may be said that the Board directly administers every facet of the occupation's activities. Physicians are embedded in the Board and the numerous Ministerially appointed advisory committees. The government bodies of the Minister and the Cabinet retain the greater overall power.

The Department of Hospitals and Medical Care has only indirect power over P.T. occupational activities as it related to its members and some aspects of its services. The Department plans and funds hospital construction and it funds the services provided within the hospitals and private practice along with some other programs. Therefore, this department's administrative power directly affects physical therapy activities in private practices and both physical therapy and respiratory therapy activities in hospitals. The activities of medicine are similarly affected in these work domains. The department has a complex top administrative structure above the division level. One position in this structure is administratively mandated as a medical position and a physician is placed in another. P.T. and R.T. members are not seen to be represented in the top administrative positions. Since the Minister can pass administrative responsibility to his employees, this may give control to medicine but not to paramedicals, within this important jurisdiction. The Minister must answer to Cabinet for actions taken by this department.

The Department of Community and Occupational Health has a jurisdiction of many activities over a wide range of health activities. It may investigate, regulate, punish, fund research and fund activities concerned with public health. These activities include home care and communicable diseases as well as occupational health and safety. Its jurisdiction is vaguely defined by the Acts and Regulations it administers, and again the Minister may pass many of these responsibilities to a government employee. But the departmental structure here above the divisional level is simple consisting of a Deputy Minister and a Minister. However, since the activities of the Public Health Division are primarily administered at the local level, it is the control of the local unit that is important and interestingly, this unit must include a mandated physician. The administration of R.T. and P.T. services is only a small part of a very wide jurisdiction but the important level of administrative power is at the local public health unit and physicians are embedded there. In this case, as well as in others, the Minister in charge of the department is answerable to the Cabinet.

This pattern is repeated in the legislation of the government departments whose combined jurisdiction encompasses the entire health system. It indicates another way in which strategically placed physicians influence the definition of health care issues. But again, it is the Cabinet that must pass any formal regulations proposed within the jurisdictional responsibility of the Minister in charge of a department. Specifically, with regard to the important area of funding, Cabinet must pass any regulations allowing the Minister to delegate responsibility to government employees and it is the Cabinet that sets the terms regarding the types of organizations eligible for grants and further conditions including terms of repayment.

With regard then, to government coordinated administrative power over the paramedical occupations, for R.T., three government agencies directly administer their activities encompassing its entire membership and service jurisdiction. For P.T., two government agencies administer the same jurisdiction but this administration is implemented indirectly over important P.T. privileges found in their occupational legislation and directly over the rest as found in institutional and funding legislation. R.T. activities then are more directly administered by a government/medical administrative structure of governmental agencies, than are P.T.

The situation which consists of direct government administrative power over some occupations combined with administrative isolation, reinforces the lack of control for paramedicals under the Health Disciplines Act. That is, the Health Disciplines Board with its physician members can narrowly focus its attention and power over paramedicals' activities since its does not have to deal with other health issues. P.T. occupational legislation is more indirectly monitored by a department that is more fully integrated into the health administrative grid. The institutional and funding legislation of both occupations is directly monitored by the two government departments that are currently fully integrated at the department level and therefore do not deal exclusively with paramedical occupations. However, all these departments are fully integrated at the Cabinet level. And Cabinet, given its wider jurisdiction of interest may wish to redirect the importance of the priorities of the health departments as put forward by their respective Ministers, such as the funding of various health programs.

The recommendations of The **Rainbow Report** reinforce the point that administrative structures which are established and maintained by government may be influenced by their physician members whose interests are not necessarily those of the paramedical occupations they administer. In Alford's (1975) words, these paramedical occupations will have to more actively push for control of their activities than does the structurally embedded medical profession, to defend theirs. Interestingly, the recommendations of the report go beyond advocating the strategic positioning of physicians within government health administrative agencies. They include the establishment of new agencies which are more independent of government and which should also have governing rights. These recommendations could raise questions of the amicability of government and medical interests, as viewed by medical profession in 1988.

Cabinet also has governing rights that have greater power over R.T. occupational activities through the Health Disciplines Board, than for P.T. through its Council. That is due to the fact that it is a government agency that more directly answers to Cabinet for R.T.. And three Ministers of this Cabinet whose combined jurisdiction encompasses the health system have important governing rights to initiate and set many of the stipulations within most aspects of the health care system and they retain varying degrees of power over the two paramedicals studied. That is, their combined governing rights, as well as those of Cabinet, more directly and extensively impinge on R.T. activities than on P.T..

P.T. has also been granted important governing rights. Its members must adhere to important occupational by-laws set independently by their own Council and which encompass important P.T. activities. Whereas, R.T. does not have important governing rights.

Within the pattern of relations, it was shown that government agencies administer both the membership and supply of services of the occupations studied. However, the state's power over R.T. is more extensive and direct than its power over P.T.. Medicine's power was shown to be extensive due to its strategic positioning in government agencies with administering rights. In the final analysis though, it is the state that has the greater power over paramedicals since it has many governing rights over their activities.

D. CONCLUSION

Occupational control is seen as occurring within two marketplaces or arenas: Level I, the economic marketplace, whose site is the health division of labour in which closure or control of the restriction of members and of the supply of services, occurs; and Level II, the political marketplace, whose site is the institutional framework of administrative and governing rights in which government and occupational control and power of these rights, occurs. And following Gilb (1966), it was asserted that any rights granted, changed or rescinded within the institutional framework, would affect control of the health division of labour, presumably in an indirect, nonspecific way; but not vice versa. Therefore it is vital for an occupation to have some administrative and governing rights, preferably of both its membership and services.

As described in Chapter VII, P.T. has been given some important administrative and governing rights; whereas R.T. has not. Furthermore, government agencies such as the Health Disciplines Board have been created to more directly and specifically monitor some occupation's activities within health care marketplace including those of R.T.. This is even more intensive than Gilb's analysis would have predicted. That is, government agencies have the right to initiate the terms of R.T. occupational legislation. For

P.T. many of these same rights are held by the P.T. Council. The power relationships of these two paramedical occupations therefore, differs between levels with P.T. being granted a pattern more similar to medicine than would be predicted in the literature and with R.T. being granted a pattern not found in the literature.

That is, with regard to the closure of R.T. membership within Level I, a government established and maintained body with mandated physician members, the Health Disciplines Board, initiates the terms in their occupational legislation. For P.T., these privileges are held by their own member elected and maintained Council. And with regard to control of the supply of services, the other aspect of Level I, the initiating of the terms within the respective occupational legislation follows the pattern of the closure of members. That is, the government agency of occupations initiates the terms for R.T. and the P.T. Council does so, for P.T.

Furthermore, the initiation of terms within institutional and funding legislation of the supply of services within Level I is done by other government bodies such as Departments related to health, their Ministers and Cabinet. Government then, through its power to legislate and to singly fund most of the health care services and the supplies, retains significant power over the supply of services of both paramedicals within Level I.

Therefore in 1988 in Alberta, a framework of government agencies more directly and specifically retains power within the economic marketplace than was predicted by a Gilbean (1966) analysis. Moreover, this power is greater over R.T.

This pattern of inter-level interdependence is further illustrated by the differences of R.T. and P.T. patterns of power within the administrative and governing rights of Level II. From their respective occupational legislation, it was shown that the P.T. Council has been given important administrative rights over the management and administration of its member register and important by-law governing rights over both its membership and services. For instance, the P.T. Council has been given the right through the by-law provision to accredit the private practices of Physical Therapists and to authorize members of a P.T. Council committee to inspect them. For R.T., it is the Registrar of the government established and maintained Health Disciplines Board that primarily manages and administers its register and inspects private practices. The R.T. Committee has few bylaw governing rights over either its members or its services: as noted, their by-law provision is more narrowly limited to committee administration.

Therefore, within Level II, the P.T. Council carries out the administration and sets some of the terms of its membership and within a limited jurisdiction of its supply of services, whereas a government board does this for R.T.. Again however, as found within the terms of the institutional and funding legislation, it is a structure of government institutions that both administers and governs a greater portion of the supply of services of both occupations.

The conclusion that P.T. has been granted a pattern which has given it important occupational control whereas, R.T. has a pattern of more subservience to both government and medicine which has given R.T. less control, is well illustrated in the analytic description of chapters VI and VII. These patterns show up in the occupational legislation, both within the specific terms and how the legislation was implemented. These different patterns are reflected in the different forms of legislation, i.e.. in acts, regulations and by-laws whose terms are set by the different government and occupational bodies who possess different governing rights. That is, they are implemented by different legislative means - i.e., through the Legislature, the Lieutenant Governor-in-Council and Occupational By-law. The result is that terms for occupational control will be found in the occupational act, regulation and its by-laws.

Having occupational rights, responsibilities, restrictions and relations established by the terms of an occupational act grants an occupation important control in that, while the terms are established in the most occupationally indirect manner, they are set by a political body of publically elected members from the entire geographical political jurisdiction i.e., from the legislative assembly. Compared to other government bodies, this assembly is viewed by the occupations as being less influenced by interested health occupational stakeholders such as medicine because it has the widest jurisdiction of interest (Boase 1982). Once in place, favourable terms located in an Act, are also viewed as being the hardest to change.

The most important way for an occupation to gain absolute control is to be granted through the enabling terms of an occupational act, the right of its occupational body to pass bylaws on critical aspects of its membership and supply of its services. Bylaws are initiated and set directly by the occupation through its legally established council and its membership; they are not usually subject to public and other stakeholder scrutiny.

Conversely, the implementation method that most restricts occupational control is by regulation since the terms are set indirectly by the most powerful government body (the Cabinet) rather than by an occupational body. Therefore, the terms are set by an intermediate but powerful government body which may also be influenced by powerful stakeholders such as medicine. Furthermore, regulations are dependent on, and may be reinforced by, terms within the related act. And they can be easily changed. Occupations recognize the limiting nature of this implementation method and this is illustrated by the fact that there are no physician regulations in 1988 in Alberta, only an occupational act and by-laws.

R.T. occupational control is initially established within the terms of the **Health Disciplines Act**. Specific terms of that act establish some of the definition of R.T.'s position in the health care marketplace. More importantly, the terms also establish a government administrative agency, the Health Disciplines Board. Enabling terms grant this government agency important administrative rights including the right to initiate terms of legislation that are important to R.T. control . Therefore they will be found in the R.T. Regulations.

Specific terms within the act also establish two alternative occupation administrative bodies, one form will be set in regulations for each occupation under the omnibus act, which includes R.T.. But enabling terms of the act grant either occupational body only very limited administrative and fewer governing rights. For R.T., under a committee/board relationship, their administrative rights were primarily related to their register administration; they were limited to only advising the board on other matters. While their governing rights included the right to pass by-laws these were limited to matters pertaining to governing of their committee. Enabling terms within the **Health Disciplines Act** however, grant more governing rights to the Minister and the Cabinet over all the activities of the board. These terms will be found in the regulations of R.T..

P.T. on the other hand, has much of its control set in the terms of its own occupational act, the **Physical Therapy Profession Act**. In this instance, the terms of this act more specifically position this paramedical occupation in the health care marketplace as it relates to the dimensions in Level I. With regard to Level II, terms within this act also establish the P.T. occupational bodies and enabling terms grant to these occupational bodies, both important administrative and governing rights. That is, the P.T. Council has many administrative rights as well as the right to initiate regulations which, once passed by Cabinet, become administrative law. But P.T. also has governing rights and these allow the occupation to pass by-laws over an important jurisdiction of occupational activities.

In summary: R.T. control is set in terms that grant it less control in Level I; that establish a government agency which has important administrative rights and the power to initiate regulations; and that grants a government minister and the Cabinet important governing rights over it. There are few governing rights granted to their occupational body. Furthermore, the terms that are especially important to their control are set by regulation which are not only dependent upon terms within the act but they are initiated by a government board rather than an occupational body. They are also set, by the most powerful government body, the Cabinet. Important P.T. control is set within the terms of their act and their by-laws which are either initiated, or initiated and set by their own occupational body. That is, they have important specific terms, have an occupational body with important administrative and governing rights and have most of them set more permanently in their own act or passed into by-laws.

Compared to P.T., the pattern of power for R.T. is one of more subservience; in Level I this subservience is to medicine and government administrative agencies and in Level II it is to the state through its administrative agencies and governing bodies. Medicine's power in the formal sense, is due to their structural embeddedness within the government administrative structure but government maintains the final governing power. And as was described earlier, the difference between the occupations' patterns of power is generally reinforced by the terms of the institution and funding legislation as well as the legislation of the government agencies.

Finally, the purpose of this study was to see if in 1988 in Alberta, a paramedical occupation could have achieved any occupational control of its activities.

Therefore, the final question to be addressed is to see if the patterns of control and power relations just described, signify that the occupation has a monopoly or complete control over their members or supply of services. To be granted absolute control, paramedical occupations must have occupational control granted in some form of a dejure by-law monopoly. The terms, preferably of their occupational act, must specify the extent of formally required member adherence to various forms of occupational legislation including bylaws, the extent of the sanctions that may be imposed for any violations including register cancellation and what that means to the practitioner, in addition to the extent of activities over which the occupational body may pass bylaws.

As was described earlier, R.T. does not have such a pattern: there are no terms specifically requiring members to obey the bylaws, sanctions are not effective since being registered is not a formal requirement for practising in the various work domains; and the jurisdiction over which the R.T. Committee may pass by-laws is limited to the functioning of the R.T. Committee itself.

P.T. does have an effective monopoly by-law pattern which gives it power over its members and service delivery. Within its occupational act, terms specify that members must follow all terms of the act and accompanying regulations. Members under investigation must follow the occupational by-laws as well. Additionally, within its regulations, the terms of the code of ethics require that a member must report another member who violates any terms of the act, regulations or bylaws. Violations are punishable in the extreme, by cancellation of membership. Cancellation is an intense form of control because it may effectively prohibit that member from practising. But equally important is the fact that the occupational council and members may pass bylaws over a jurisdiction of some critical aspects of the restriction of its membership such as College membership categories and privileges and over the delivery of its services such as the accreditation of clinical work sites. These are in addition to the important control of the administration of the college, council, committees and registrar. P.T. then, has been granted a moderately effective monopoly over some of its activities whereas R.T. has not.

The monopoly that P.T. holds refers to the specific market within which the monopoly is located. The exclusive right to offer P.T. services is restricted within the boundaries of the medical marketplace itself. Similar services are offered in alternative markets or a free market. Formal rules give P.T. a monopoly in the medical marketplace but they cannot practice in these other markets. While this point must not be forgotten, it is also best to remember that the research topic is about the paramedicals in the medical marketplace.

The patterns of power just described which focus on the relationships among paramedicals, medicine and the state can be labelled as either a state dominated tripartite relationship, with regard to the pattern of R.T. and a more balanced occupational dominated tripartite relationship with regard to the P.T. pattern. Neither of these patterns would have been predicted from the literature.

In the state dominated tripartite relationship, the state has governing power and extensive and direct administrative power over the paramedical's activities. Furthermore, medicine's power is held indirectly but powerfully held through its position on these state administrative agencies that oversee the medical marketplace. Therefore, medicine's power is found both directly in the marketplace due to gatekeeping rights and indirectly through its position within the state administering agencies. The occupation's relationship to both medicine and the state is one of subservience.

In the occupational dominated tripartite relationship, both the state and the occupation have important governing rights. And the state administering structure while important, is less direct and extensive over the paramedical activities. The occupation however, has its own administering rights over its activities especially its membership. Therefore, medicine's power is less over this paramedical's activities since the state has fewer administering powers. In addition, the paramedical has only the referral gatekeeping restriction placed on the delivery of its services. However, this allows it the right to function within the medical division of labour. This occupation then has important control since it has a more balanced relationship to medicine and the state. It is not claimed that within this pattern of power that the state is not important nor that medicine is not involved, only that the paramedical occupation has important control of its activities.

CHAPTER IX: CONCLUSION

A. WHAT WAS GAINED BY THIS RESEARCH?

This study was conducted in order to discover whether two somewhat similar paramedical occupations had been granted any formal occupational control of its activities. If so, the additional task was to discover if the form and degree of control for each paramedical occupation was similar or not. This study was able to demonstrate that; both paramedicals have some formal occupational control especially over its members; they have extensive and complicated relationships to both medicine and the state; and the forms and degree of control vary considerably. The form of occupational control that Physical Therapy has achieved is stronger and it is similar in a limited way, to the form usually associated with medicine. Given the literature this was surprising. The weaker form of control that Respiratory Therapy has achieved is not found in the literature.

Of the major authors in this area, Larkin (1983, 1988) provides the most direction. He describes the tripartite relationships between the state, medicine and the paramedicals. He would allow for the possibility that the state and the paramedical occupations would actively pursue their own interests and that the state could have a direct relationship with paramedicals.

Larkin's work extends that of Berlant (1975) and Freidson (1970a, 1970b). From Berlant, Larkin would accept the ideas that the paramedical's pursuit of a monopoly would be viewed as rational economic conduct on their part but in this case the constraints opposing them would be a state:medicine combination of interests. Therefore, the monopolization strategies of paramedicals would include those of social closure as well as others needed to achieve market closure and domination of the system. Larkin expands Freidson's work to examine the relationships of the three groups and to allow for the possibility that due to the complexity of these relationships the concepts of autonomy and dominance have many dimensions. Larkin would then stress that these relationships do not take a zero:sum dynamic in which for instance, a rise in control of a occupation's autonomy in the marketplace automatically diminishes the dominance of the system by another occupation.

Taking general direction from these authors, the theoretical framework was initially developed. However, this empirical study extended even Larkin's work to provide a more specific description of the means by which the state may implement its interests. The framework incorporates the work of other authors such as Alford (1975), Evans (1983, 1987), Gilb (1966), Gross (1984) and Palmer (1985). This combination of works helped to establish the sixteen dimensions of the framework and the description following these dimensions formed the basis for the results of this study.

The purpose of the framework used in the study was to organize the detail found in the data in order to provide an analytical description that would be sociologically meaningful and replicable. The use of this framework did systematize the investigation and it did allow for a replication of the study between the two paramedical occupations in a meaningful way as was shown in the results of the comparison between them.

The dimensions within the framework appeared to be complete in that it covered the formal aspects of the occupation's activities. For instance, the addition of separate dimensions for code of ethics and income structure, as well as the more familiar right to title and scope of practice, greatly clarified the descriptions and comparisons in Level I. The dimensions of Level II are not as succinctly structured as those in Level I. The second level is difficult to work with, given the very complicated number and type of agencies or bodies, and their related duties and relationships. It is hoped that further research would clarify these dimensions as the interagency structure reflected in Level II will be the arena in which many conflicts will be fought and resolved in the future. It is however, important to retain the separation between administrative and governing rights because this led to important comparative differences between Physical Therapy and Respiratory Therapy. And this distinction has largely been ignored.

Specific terms within acts can create various government agencies and occupational bodies while enabling terms will grant them specific administrative and perhaps, governing rights. As was described earlier, depending upon which agency or body has been granted these rights, further terms are implemented by different legislative means such as by regulation or by by-law. This study has really only touched on these facets of occupational control. Further comparisons would help to clarify these dimensions; that is to more fully describe the new government agencies that may be established such as a Health Disciplines Board, and to extend the discussion of their related administrative and governing rights.

If one is describing an occupation's legal privileges, one must use government documents as data. The question then becomes: Which documents?. Occupational legislation was of course, the place to begin but as the framework developed, it became imperative to include institutional and funding legislation. And the administrative and governing legislation needed to be included, as well as other types of government documents such as annual reports. Fortunately, in Alberta, government document titles are listed in a government publication of titles and they are readily available. The problem here will always be to know which specific documents to include and which to discard, for there are many pieces of legislation on very specific topics. The framework assisted in this decision. Furthermore, replication of the study over two occupations indicates that the documents used were the most vital ones, however, other documents may assist in expanding the descriptions.

In all research there is a problem of coding the research material and this problem is certainly evident in this study. However, a very specific chain of evidence was followed and repeated for the second occupation. The use of printed cards containing single pieces of information which could then be rearranged to correspond to the dimensions of the framework, greatly eliminated some of the confusion and biases that could occur. Nevertheless, one is always aware that some detail is lost. Since this study was not a complete description of the occupation's legal privileges but rather an analytical description of the occupation's forms of control and power relations, loss was negligible. The resultant descriptions of two different patterns of control and power relations between the occupations would testify to the fact that this chain of evidence procedure was reasonably effective. Therefore, the study was able to show that paramedical occupations have some important occupational control and that there are different forms of control. In this manner, the results would generally justify the utility of a comparative case study and the use of a multidimensional framework.

B. FUTURE DIRECTIONS

Now that this study has been completed and proven to be at the least doable, further research using the framework should be undertaken. It would be interesting to compare the findings of this study to the results of studies done with other paramedicals in Alberta, at the same point in time. It would also be interesting to compare the results to a study of the same paramedicals but in a different political jurisdiction. For instance occupations within the different provincial jurisdictions in Canada would be especially pertinent since many provinces are currently passing new occupational legislation on paramedicals. And a more general comparison may be made between countries to see if for instance, the patterns found in Alberta for Physical Therapy and Respiratory Therapy are general patterns, or whether they are specific. If general, these patterns might still be limited to the so-called welfare states or, to industrialized nations. The results of this study then could form the basis of comparisons across many types of occupations and across various types of jurisdictions.

One of the perennial questions asked but never answered adequately in medical sociology is whether medical dominance is declining. If one views medical dominance as an intense form of occupational control, it may be as Larkin (1988; 1983) asserts, that the more important question is not whether it is declining in an absolute sense but whether its form and degree is changing. An important way to assess this change may be to research changes in paramedical patterns of control and the changing relationships between paramedicals, medicine and the state. By researching the question in this way, changes in the relative positions of medicine, the state and paramedicals would be central in the research design.

Or, one can move forward in time to examine the 1989 and 1990 legislation for the same groups. For instance in 1990, P.T. was granted exclusive rights over their previous title 'physiotherapy' [PTA: s20(3)] thereby strengthening its position in the health division of labour. R.T. now has an association:Board relationship [RTR: s1(b)] which, according to the related enabling term within the act, strengthens the occupational body's role in its register administration. The Departments of Hospitals and Medical Care and Community and Occupational Health have generally been combined into a single department [Department of Health Act: s1,15] thereby increasing administrative coordination by the government. This will probably increase state control of the health system, including its power over P.T. and R.T. services since it will be in a position to more effectively administer the many facets of the institutions, programs and private practices in which their services are delivered. In this way the results of this study would be extended through time to give us some knowledge about how the current forms are changing.

Licensing establishes forms of occupational control and sets the parameters within which informal occupational, inter-occupational, and state activity takes place. A good example of the constraining and facilitating role of the legal framework comes from Saskatchewan. In 1964, the provincial government hired physicians from the United Kingdom during their famous doctor's strike. These state actions were only possible since a term within the medical provincial act allowed U.K. the physicians automatic membership on the Saskatchewan physician register (Hetherington 1966). Studies which examine the relationship between formal control and informal action are needed.

Informal action taken by members of an occupation may reinforce or negate the formal patterns of privilege and restriction. For instance, the 'standing orders' of a hospital ward are part of the organizational context but they are not formal in the legislative sense. Nonetheless, the standing orders may allow paramedicals such as R.T.

members, to treat a patient upon admission to the ward, and then to inform the physician of the specific R.T. treatment given. This would be unexpected given the terms of the **Health Disciplines Act**. Or hospital administrators may insist on hiring R.T. members although this is not required by law, to prevent any possible law suits for providing incompetent treatment. Therefore, a study of informal control using different research methods, focusing on occupational informal control and restrictions would be especially interesting and fruitful if compared to the formal privileges.

C. CONCLUSIONS

Many theoretical questions on the nature of occupations in general, and of the medical and paramedical occupations in particular, still need to be answered. And much empirical research still needs to be carried out by sociologists working in this area. Only by overcoming the abstract, unilinear, definitional concept of autonomy and the tendency to dismiss as unimportant, those occupations seen to not have this attribute, can research enlarge this empirical narrowness and reduce this theoretical deficiency. Only by asking the generic question of what constitutes an occupation's control and power vis a vis other groups is one able to conduct research on all types of occupations and not just on those labelled professions. There is merit in seeing that occupational control takes many forms; that in the case of the health occupations it is not 'all or nothing'. By developing a framework of dimensions one can detail systematically and concretely, the forms of control and the power relations of a given occupation. This was the task for the study here.

Based on the results of the study, and assuming paramedicals want to enlarge their formal basis of control, the best practical advice to paramedical occupations is the following: Establish a permanent legislation committee in order to understand what the current legislation means for occupational control and for their relations to medicine and government; monitor relevant legislation for any changes therein; and lobby government bodies for changes in their interest. The medical profession through its by-laws provision, has established a formal legislation committee charged with these responsibilities [MPB: s25]. In both the monitoring and lobbying functions, these legislative committees could be more effective if they would join with other paramedical occupations with similar interests. One obvious area to change, is to make it mandatory for government health care institutions to hire members registered under the **Health Disciplines Act**.

To be especially effective, paramedical lobbying should be aimed at the Ministerial and Cabinet level given that the government administrative agencies have physicians structurally embedded within them and physicians historically have not supported paramedical aspirations for more occupational control. Paramedicals should publically state their interests so as to enlist public support such as the midwives are currently doing. The main point is to ensure that the Minister and Cabinet directly hear and fully understand the paramedical occupations' concerns. Generally, they should specifically lobby for terms within their occupational legislation to enlarge their control on the dimensions reflected in the framework especially for more control of the supply of their services, and for enabling terms that grant the occupation an important bylaw pattern.

The monitoring functions of the committee are especially important for the paramedicals legislated under **the Health Disciplines Act** since their occupational control is specifically established in regulations whose terms are dependent on enabling terms within the act. Most of their activities are established and monitored by the board which is also established by the same act. Therefore, terms within the act may change board functions and relationships to the occupational bodies. For instance, changes within the act may establish new advisory committees to the board which would more likely include physicians than paramedical members. The monitoring of activities by this committee should include the attendance of all board meetings and a direct liaison with the members of the Professions and Occupations Bureau so as to further understand, appreciate and influence their actions. Much of the actual administration of occupational legislation is done by the Professions and Occupations Bureau.

Medicine is very aware of these recommendations made for the paramedicals. They have a permanent committee that performs these functions and this committee has been very effective. Paramedicals should therefore follow suit and assert their own interests in the legislative context. Alteratively, these occupations should have their members placed in important administrative positions on government agencies or elected to the legislature and placed in important governing positions.

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APPENDIX I
OFFICIAL 1988 GOVERNMENT DOCUMENTS

OFFICIAL 1988 GOVERNMENT DOCUMENTS

The following government documents were listed in the following publication:

List of Alberta Publications and Legislation November 1988
Public Affairs Bureau: Publication Branch
Government of Alberta

A * will mark those items not listed in:
List of Alberta Publications and Legislation, November 1988.
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1988

PROFESSIONAL (OCCUPATIONAL) ACTS/REGULATIONS

Physical Therapy Profession Act.
Administered by Alberta Department of Health.
Amended by Chapt. 31/88.
Chapt. p-7.5 1984.

Physical Therapy Profession Act: 'General Regulation'.
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Health Disciplines Act.
Administered by the Honorable Dr. Ian C. Reid.
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Amended by Alberta Regulation 508/87.
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Medical Profession Act.
Administered by the Alberta Department of Hospitals and Medical Care.
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ACTS/REGULATIONS OF HEALTH CARE INSTITUTIONS AND PROGRAMs

Hospitals Act.
Administered by the Alberta Department of Health:
Office Consolidation to Sept. 30/85.
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Provincial General Hospitals Act.
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Alberta Hospital Association Act.
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Alberta Health Care Insurance Act: 'Claims for Benefits Regulation'.
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Hospitals Act: 'Alberta Hospitalization Benefits Regulations'.
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Public Health Act: 'Coordinated Home Care Program Regulation'.
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Public Health Act: 'Alberta Aids to Daily Living and Extended Health Benefits Regulation'.
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Organization of the Government of Alberta, August 1987
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COMMISSION REPORTS

**Premier's Commission on Future Health Care for Albertans (Hyndman Commission).*
'Newsletter: September 88.'
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'Interim Report: Caring and Commitment. Concerns of Nurses in the Hospital and Nursing Home system. June 1988.'

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Volume I
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